

Case Number:	CM14-0207030		
Date Assigned:	12/19/2014	Date of Injury:	11/21/2012
Decision Date:	02/12/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/10/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60 year old female with an injury date on 11/21/12. The patient complains of constant, severe, and debilitating right hand/wrist pain that is "unbearable at times" per 11/20/14 report. The pain radiates up her right arm to her right shoulder/neck with throbbing, redness, and heat per 11/20/14 report. Her right upper extremity is weak and she is unable to use it, and there is also right hand stiffness/atrophy due to disuse per 10/23/14 report. Based on the 11/20/14 progress report provided by the treating physician, the diagnosis is right upper extremity chronic regional pain syndrome. A physical exam on 11/20/14 showed "hyperesthesia and allodynia over dorsal aspect of right wrist/hand/fingers. Skin/muscles of right hand/wrist are atrophic, skin is shiny and blistered." No range of motion testing of right hand/wrist was included in provided reports. The patient's treatment history includes medications, work modifications, knee bracing. The treating physician is requesting Percocet 10/325mg #120. The utilization review determination being challenged is dated 12/3/14. The requesting physician provided treatment reports from 6/17/14 to 11/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-78, 88-89.

Decision rationale: This patient presents with right hand/wrist pain, right shoulder/neck pain. The provider has asked for Percocet 10/325MG #120 on 11/20/14. The patient averages about 6 Percocet per day for pain not relieved by other medications per 6/17/14 report. Patient has been taking Percocet since 6/17/14 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, activities of daily living (ADLs), adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the provider does not indicate a decrease in pain with current medications there is no discussion of this medication's efficacy in terms of functional improvement using numerical scale or validated instrument. Quality of life change, or increase in specific activities of daily living are not discussed. There is no discussion of return to work or change in work status attributed to the use of the opiate. The utilization review letter from 12/3/14, states work modification, but none of the reports from 6/17/14 to 11/20/14 mention work status with 8/11/14 stating that the patient is not working. Urine toxicology is not mentioned, nor is any other aberrant behavior monitoring provided such as CURES report. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, a slow taper off the medication is recommended at this time. The request is not medically necessary.