MAXIMUS Federal Services

Case Number:	CM15-0102290		
Date Assigned:	06/04/2015	Date of Injury:	03/02/1999
Decision Date:	07/10/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	05/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Connecticut, California, Virginia
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 injured worker was a 74 year old male, who sustained an industrial injury, March 2, 1999. The injured worker previously received the following treatments left wrist x-rays, right wrist injection, Cyclobenzaprine, Flomax, Lidocaine ointment, Oxycodone, Percocet, right wrist fusion, right wrist surgeries times 3 and left wrist surgeries times 3. The injured worker was diagnosed with status post left proximal row corpectomy with progressive cystic formation of the capitate, status post right wrist fusion, right worse than the left distal radioulnar joint arthritis, status post multiple injections, status post bilateral trigger finger releases, status post revision right carpal tunnel release and ulnar nerve release at the elbow, right wrist injection and left wrist over use. According to progress note of March 17, 2015, the injured workers chief complaint was left wrist pain. The injured worker described as burning discomfort in the wrist at rest with grasping and forceful use, the injured worker described a severe central wrist pain; even simple activities such as opening the refrigerator worsens the discomfort. The physical exam noted wrist range of motion was quite functional on the left. There was tenderness to palpation of the capitate from dorsal. There was no pain with flexion or extension, but the ulnar deviation was quite painful. The treatment plan included a prescription for Oxycodone and Amitriptyline.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription Of Oxycontin 40mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably modified the request to facilitate appropriate weaning. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for Norco is not considered medically necessary.

1 Prescription Of Amitriptyline 10mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti depressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trycyclics Page(s): 13.

Decision rationale: The MTUS covers use of antidepressants in detail, recommending use of tricyclic antidepressants as a first-line agent for neuropathic pain unless they are ineffective. In this case it appears that the drug was a reasonable choice but its overall efficacy is not clear based on the provided documents. Close monitoring should occur in order objectively evaluate for evidence of functional improvement on the medication in order to facilitate future and continued treatment planning. Therefore the request in this case is considered medically appropriate but further continuation of treatment should include detailed objective findings that support continued use, especially given the risk of chronic treatment.