

<b>Case Number:</b>	CM14-0060814		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	09/12/2005
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 56-year-old patient who sustained a work-related injury on September 12, 2005. Subsequently the patient developed chronic low back pain. According to a progress report dated on September 19, 2011, the patient complained of lower back pain. The patient was documented to receive Percocet, Lidoderm patches, Kadian, Amitiza, Zanaflex, Trazadone, and Gabapentin. The objective findings on examination were: range of motion of the lumbar spine was limited; TTP paravertebral muscles; shoulder ROM restricted and preservation of motor strength. The patient was diagnosed with spinal/lumbar spine DDD, post laminectomy syndrome, and mood disorder. The treatment plan included sessions of physical therapy and therapeutic massage. The progress report dated November 13, 2013 reported that the patient was evaluated in follow up for chronic low back pain and right shoulder pain. The pain issues are reported as unchanged. The objective findings on examination included: slow gait; lumbar spine with surgical scars; range of motion restricted by pain, mostly in extension; tenderness to palpation to the paravertebral muscles; right shoulder abduction was limited probably by pain. The patient neurological examination was normal. The diagnosis was lumbar spine DDD, mood disorder, joint pain shoulder, and postlaminectomy syndrome. The treatment plan included SI joint injection, continue Gabapentin, continue Kadian, Percocet as needed, refill Flexeril, and continue Lidoderm and Amitiza. The follow-up report dated March 5, 2014 reported that the pain issues were reported as unchanged. The objective findings on examination remained unchanged as well as the diagnoses. The provider requested authorization to use Lidoderm 5% patch, Percocet, and Kadian.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patch #60 refill times 5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch), page(s) 56 Page(s): 56.

**Decision rationale:** According to MTUS guidelines, Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin). In this case, there is no documentation that the patient developed neuropathic pain that did not respond for first line therapy and the need for Lidoderm patch is unclear. According to the patient records, Lidoderm was used since 2011 without significant documentation of continuous improvement. Therefore, the prescription of Lidoderm patch 5% #60 refill times 5 is not medically necessary.

**Percocet 510/325 mg tab, #180 refill times 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Anti-inflammatory medications; Opioids for chronic pain Page(s): 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179.

**Decision rationale:** According to MTUS guidelines, Percocet is a short acting opioids is seen an effective medication to control pain. According to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status,appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. The patient was already on Percocet since 2011 without documentation of significant functional improvement or pain reduction. The patient was no back to work and there is no documentation of quality of life improvement. There is no continuous documentation of compliance, side effect or use/non use of illicit drugs. Therefore, the prescription of Percocet 510/325 mg #180 refill times 1 is not medically necessary.

**Kadian 10mg cap ER Pel, #90 refill times 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines < Criteria for use of opioids, page(s) 76-79 Page(s): 76-79.

**Decision rationale:** Kadian is a brand of morphine sulfate. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. Despite the continuous use of Kadian since 2011, there is no documentation of functional improvement and reduction in pain. There is no recent and continuous documentation of compliance of the patient with her medications. There is no recent documentation of failure of first line pain medications to manage the patient pain. Therefore, the prescription of Kadian 10mg cap ER Pel, #90 refill times 1 is not medically necessary.