

<b>Case Number:</b>	CM14-0094503		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/07/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

This is a 44-year-old male patient with a 3/17/12 date of injury. The exact mechanism of injury has not been described. A progress report dated on 5/12/14 indicated that the patient complained of ongoing pain and edema, temperature asymmetry and stiffness in the left lower extremity. He rated his pain 4-8/10 on the VAS scale. Physical exam revealed positive allodynia, hyperalgesia and redness in the left lower calf. The left ankle was cooler than the right ankle. There was edema in the left ankle and trophic changes with hair loss on the left ankle to the calf. He was diagnosed with Reflex sympathetic dystrophy of the lower limb, Ankle and foot joint pain, and chronic pain syndrome. Treatment to date: medication management, lumbar sympathetic block. There is documentation of a previous 5/20/14 adverse determination. The decision for denial was not available in the medical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lyrica 150 mg 2 capsules po tid #180 x 3 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 19-20. Decision based on Non-MTUS Citation Other Medical

Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Lyrica. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy of the lower limb, pain in joint and chronic pain syndrome. In addition, there is documentation of ongoing treatment with Lyrica. Furthermore, there is documentation of neuropathic pain. Lastly, given documentation that Lyrica allows the patient to perform activities of daily living, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Lyrica use to date. Therefore, based on guidelines and a review of the evidence, the request for Lyrica 150 mg 2 capsules po tid #180 x 3 refills is medically necessary.

**Percocet 10/325 mg 1 tablet prn po every 4-6 hours #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: Percocet. Decision based on Non-MTUS Citation Washington, 2002; Colorado, 2002; Ontario, 2000

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy of the lower limb, pain in joint, and chronic pain syndrome. In addition, there is documentation of ongoing treatment with Percocet. Furthermore, given documentation that Percocet allows the patient to perform activities of daily living, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Percocet use to date. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325 mg 1 tablet prn po every 4-6 hours #180 is not medically necessary.

