

<b>Case Number:</b>	CM15-0134073		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	12/16/2013
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 is a 28 year old female, who sustained an industrial injury on 12/16/2013, after a fall onto her left hand and wrist. The injured worker was diagnosed as having a history of complex regional pain syndrome of the left upper extremity, left wrist sprain, and left wrist tendinitis. Treatment to date has included diagnostics, left wrist surgery for de Quervain's syndrome, platelet rich plasma injection in left wrist (4/24/2015), left stellate ganglion block (1/27/2015), spinal cord stimulator with revision, and medications. Currently (6/10/2015), the injured worker was 3 weeks post spinal cord stimulator revision. She reported improved left wrist pain. She was currently using Oxycontin 40mg twice daily and Percocet 10/325mg three times daily and wished to decrease her medication intake. She reported pain and discomfort of the left upper extremity and difficulty with activities of daily living due to pain. Other medications included Lyrica and Tizanidine. The treatment plan included discontinuing Oxycontin and using Percocet eight times daily. Lidoderm patches were also noted for the left wrist. She was currently not working. Urine toxicology (5/13/2015) showed inconsistent results, however a progress report (4/20/2015) noted a request for Xanax.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 40mg #30 with 2 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, p76-80 (2) Opioids, dosing, p86 Page(s): 76-80, 86.

**Decision rationale:** The claimant sustained a work-related injury in December 2013. She underwent a left DeQuervain's release in August 2014 and now is being treated for left upper extremity CRPS. When seen on 05/13/15, there had been no improvement after a PRP injection. Her left wrist pain had intensified. There had been only two days of 50-60% pain relief after a stellate ganglion block. She was taking Percocet, Lyrica, trazodone, and tizanidine. Percocet 10/325 mg was being taken 8 times per day and her pain was still not well controlled. There was mild left forearm and wrist swelling with tenderness. There were findings consistent with her diagnosis of CRPS. OxyContin and Percocet were prescribed at a total MED (morphine equivalent dose) of 165 mg per day. On 06/10/15 there had been improvement after spinal cord stimulator revision and she was having period of time with no pain. She wanted to decrease her medications. OxyContin was discontinued and Percocet 10/325 mg was prescribed at 8 tablets per day. Guidelines recommend against opioid dosing is in excess of 120 mg oral morphine equivalents per day. In this case, when prescribed, the total MED being prescribed was more than that recommended. Although the claimant had chronic pain and the use of opioid medication may be appropriate, there were no unique features of this case that would support dosing at this level. Ongoing prescribing at this dose is not medically necessary.

**Percocet 10/325mg #240 with 2 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, p76-80 (2) Opioids, dosing, p86 Page(s): 76-80, 86.

**Decision rationale:** The claimant sustained a work-related injury in December 2013. She underwent a left DeQuervain's release in August 2014 and now is being treated for left upper extremity CRPS. When seen on 05/13/15, there had been no improvement after a PRP injection. Her left wrist pain had intensified. There had been only two days of 50-60% pain relief after a stellate ganglion block. She was taking Percocet, Lyrica, trazodone, and tizanidine. Percocet 10/325 mg was being taken 8 times per day and her pain was still not well controlled. There was mild left forearm and wrist swelling with tenderness. There were findings consistent with her diagnosis of CRPS. OxyContin and Percocet were prescribed at a total MED (morphine equivalent dose) of 165 mg per day. On 06/10/15 there had been improvement after spinal cord stimulator revision and she was having period of time with no pain. She wanted to decrease her medications. OxyContin was discontinued and Percocet 10/325 mg was prescribed at 8 tablets per day. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it was being prescribed as part of the claimant's ongoing management after spinal cord stimulator placement. There were no identified

issues of abuse or addiction and medications are providing pain control. The total MED was 120 mg per day consistent with guideline recommendations. Although she had poor pain control at this dose previously, she had improved after the spinal cord stimulator placement. However, there was a plan for further medication weaning and a three month supply was prescribed which is not medically necessary.

**Lidoderm 5% patches #10 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Lidoderm (lidocaine patch) p56-57 (2) Topical Analgesics, p111-113 Page(s): 56-57, 111-113.

**Decision rationale:** The claimant sustained a work-related injury in December 2013. She underwent a left DeQuervain's release in August 2014 and now is being treated for left upper extremity CRPS. When seen on 05/13/15, there had been no improvement after a PRP injection. Her left wrist pain had intensified. There had been only two days of 50-60% pain relief after a stellate ganglion block. She was taking Percocet, Lyrica, trazodone, and tizanidine. Percocet 10/325 mg was being taken 8 times per day and her pain was still not well controlled. There was mild left forearm and wrist swelling with tenderness. There were findings consistent with her diagnosis of CRPS. OxyContin and Percocet were prescribed at a total MED (morphine equivalent dose) of 165 mg per day. On 06/10/15 there had been improvement after spinal cord stimulator revision and she was having period of time with no pain. She wanted to decrease her medications. OxyContin was discontinued and Percocet 10/325 mg was prescribed at 8 tablets per day. In terms of topical treatments, topical lidocaine in a formulation that does not involve a dermal-patch system could be recommended for localized peripheral pain. Lidoderm is not a first-line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. In this case, there are other topical treatments that could be considered. Therefore, Lidoderm is not medically necessary.