

<b>Case Number:</b>	CM15-0162843		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	07/16/1999
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency 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 is a 55 year old female, who sustained an industrial injury on 7-16-1999. She reported right knee pain. The mechanism of injury is not indicated. The injured worker was diagnosed as having right medial knee pain recalcitrant to conservative treatment, history of lumbar spine surgery with spine stimulator, adjacent segment degenerative disease L5-S1 radiculitis, and chronic pain syndrome. Treatment to date has included medications, spinal stimulator, and x-rays of the right knee. The request is for Oxycodone, and Lidoderm patches. On 2-10-2015, reported right knee pain. She is also being treated for low back pain. She indicated her right knee pain to be worse with bending. Physical examination revealed full range of motion to the right knee; tenderness is noted along the medial joint line, medial patellofemoral ligament and medial tibial condyle. Testing revealed a negative McMurrays, anterior drawer, posterior drawer, and patella compression and apprehension signs. Her work status is noted to be per primary treating physician. She is contraindicated for magnetic resonance imaging of the right knee due to having a spine stimulator so the provider is requesting CT arthrogram of the right knee. On 2-13-2015, she was last seen on 12-19-2014. She was sent for facet blocks of the lumbar spine which she is reported to have done great with; however over the last few weeks her symptoms are starting to return. She continues to report over 60% pain relief. Physical examination revealed there is no radicular pain at present due to the spinal cord stimulator. The treatment plan included: refilling medications, rhizotomy of bilateral L5-S1, referral to pain management. Her work status and the refilled medications are not documented. On 4-6-2015, she is reported to have undergone rhizotomy and feels this has been helpful. She is noted to be

obtaining Percocet prescriptions from this provider. The physical examination revealed no radicular pain present due to the spinal cord stimulator. The treatment plan included: pain management, refilling Percocet, and follow up in 6-8 weeks. On 5-18-2015, she reported continued right knee pain and back pain. She is using Percocet, Soma, and Diclofenac. No radicular pain is noted due to the spinal cord stimulator. The treatment plan included: electrodiagnostic studies, pain management referral and follow up. On 7-8-2015, she reported back and right knee pain. Physical findings revealed a negative straight leg raise test. The treatment plan included: refilling her medications. The medications are not documented.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Oxycodone 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** Oxycodone in an opioid medication. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the quantity if medication requested indicates long-term opioid use. There is no documentation in the medical record of duration or efficacy of opioid use. In addition there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized and is not medically necessary.

**Lidoderm patch 5% (700mg patch) #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Lidoderm® (lidocaine patch).

**Decision rationale:** Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA

approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non- neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of patches planned. (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. In this case the quantity of medication requested indicates long-term use of lidocaine patch. There is no documentation in the medical record of duration or efficacy of Lidocaine use. The lack of documentation does not allow determination of necessity. The request should not be authorized and is not medically necessary.