

Case Number:	CM15-0164420		
Date Assigned:	09/01/2015	Date of Injury:	06/17/2003
Decision Date:	10/13/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/21/2015

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
 Certification(s)/Specialty: Anesthesiology

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 66 year old male who sustained an industrial injury on 06-17-2003. According to the only progress report submitted for review and dated 08-03-2015, the injured worker was seen for lumbar spine pain and thoracic spine pain. Since his last visit, authorization for 6 sessions of cognitive behavioral therapy had been obtained to facilitate tapering off of Percocet. The injured worker decided that he did not want to see a psychiatrist. He reported brief intense episodes or right lancinating sharp and stabbing thoracic spine pain. After the brief momentary flash of pain he would have an ache and burning sensation in the same area. He stated that the Lidoderm patch clearly helped with that pain. He used Lidoderm in combination with Voltaren Gel and a small amount of Cannabis between his cheeks and gums to help with sleep in the evening. This was the only way he could fall asleep. The provider noted that at the last visit Percocet was reduced from 120 to 110 per month and as a result, the injured worker returned to the office twice for Toradol shots. Four Percocet a day allowed the injured worker to work to some degree on his classic cars, go fishing and do other activities what he otherwise would not be able to do. Worst pain was rated 9 on a scale of 1-10. Least pain was rated 4. Usual pain was rated 6. Pain was worse. Sleep pattern was the same. Functionality was the same. Medication usage was the same. Past treatments included medications, chiropractic care, massage therapy and trigger point injections. Past medications included Motrin, aspirin, Lyrica, BenGay, Flector patch, Celebrex and Lidoderm patch. Current medications included Percocet, Lyrica, vitamin D3, fish oil, Fluocinolone cream, Metoprolol, Pravastatin, Levothyroxine, Tricor, Aspirin, Clopidogrel, Lidoderm patch and Voltaren gel. Diagnoses included chronic pain

syndrome, thoracic spondylosis without myelopathy, cervical spondylosis without myelopathy, lumbosacral spondylosis without myelopathy, displacement of cervical intervertebral disc without myelopathy and obesity unspecified. The treatment plan included Percocet, Lidoderm patches and Voltaren gel. Currently under review is the request for Lidoderm patches 5% #30 with 2 refills, Voltaren gel 1% with 2 refills, Percocet 10-325 mg #100 with 1 refill (to be filled 8-1 and 9-2) and Lyrica 150 mg #60 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines, topical analgesics, such as Lidoderm patches, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In this case, medical necessity of the requested topical analgesic has not been established. The requested Lidoderm patches are not medically necessary.

Voltaren gel 1% with 2 refills: 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): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The maximum dose should not exceed 32 g per day. The submitted documentation does not indicate that the injured worker had a diagnosis of

osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits that the injured worker had to the knee. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has not been established. The requested 1% Voltaren Gel is not medically necessary.

Percocet 10/325mg #100 with 1 refill (to be filled 8/1 and 9/2): 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 for chronic pain.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is lack of documentation of objective functional improvement with the use of Oxycodone/APAP. There is a lack of objective evidence of functional benefit obtained from the opioid medication. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Lyrica 150mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Pregabalin (Lyrica).

Decision rationale: According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. A "good" response to therapy with this medication is described as a 50% reduction in complaints of neuropathic pain. In this case, the patient has axial and non-neuropathic pain. Lyrica has been used in the past. However, medical necessity for the requested medication has not been established. The requested item is not medically necessary.

