

<b>Case Number:</b>	CM15-0216140		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	12/26/2011
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: Montana, Oregon, Idaho  
Certification(s)/Specialty: Orthopedic Surgery

### 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 53 year old female, who sustained an industrial injury on 12-26-2011. The injured worker was working part time as of 06-22-2015. Medical records indicated that the injured worker is undergoing treatment for anterior cervical discectomy and fusion at C3-C7 with residual. Treatment and diagnostics to date has included cervical spine surgery, cervical spine MRI, injections, acupuncture, physical therapy, and medications. Recent medications have included Lidoderm (since at least 01-27-2015), Oxycodone (since at least 02-04-2015), Flector patch, and Celebrex. Subjective data (09-01-2015 and 09-29-2015), included neck pain rated 5-6 out of 10. The treating physician noted that the injured worker's pain is "made better" with Lidoderm patch as well as Celebrex and Oxycodone (using approximately 5 to 6 tablets per day per progress report). Objective findings (09-29-2015) included an antalgic gait and decreased cervical spine range of motion. The request for authorization dated 09-26-2015 requested Oxycodone 10mg #180, Celebrex, Lidoderm patch 5% #10, acupuncture, and follow up. The Utilization Review with a decision date of 10-05-2015 modified the request for Oxycodone 10mg #180 to Oxycodone 10mg #114 to allow for continuation of a taper and denied the request for Lidoderm patch 5% #10.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 10mg #180: 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, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. 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 nonadherent) 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 for documentation of the clinical use of these controlled drugs. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. In this case the worker is 53 years old and was injured in 2011. She is being treated for neck pain. She has been treated with opioids since at least 2/4/15. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, percentage of pain relief, duration of pain relief, compliance with urine drug screens, a signed narcotic contract or that the injured worker has returned to work. The current guidelines provide very limited support to recommend treatment of non-malignant pain beyond 16 weeks. Therefore the criteria set forth in the guidelines have not been met and the request is not medically necessary.

**Lidoderm patch 5% #10: 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 rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57, regarding 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 or Lyrica). This is not a first-line treatment and is 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. Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. For non-neuropathic pain is not recommended. There is only one trial that tested 4% Lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. In this case the submitted documentation demonstrates there is no evidence of failure of first line medications such as Gabapentin or Lyrica. There is no documentation of functional improvement from this medication in the past. It is also unclear to this reviewer if this medication is being used for treatment of neuropathic or non-neuropathic pain diagnosis. Therefore the request is not medically necessary.