

<b>Case Number:</b>	CM14-0129063		
<b>Date Assigned:</b>	09/29/2014	<b>Date of Injury:</b>	01/28/2010
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 Physical Medicine & Rehabilitation, 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:

The injured worker is a 65-year-old female who reported an injury on 01/28/2010 due to an unknown mechanism. Diagnoses were chronic neck pain, degenerative cervical spondylosis, myofascial pain syndrome, chronic right shoulder pain, osteoarthritis, pain disorder with psychological/general medical condition, insomnia, persistent chronic pain. Physical examination dated 09/30/2014 revealed progressive radicular pain into both arms and right greater than the left side. Examination of the cervical spine revealed sensory loss/alteration C6, left hand (thumb/index finger), difficulty with lifting and holding up arms, positive spasms in both arms, right more than left, deep tendon reflexes, decreased right brachioradialis. Treatment plan was to continue current medications as directed. The Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LIDODERM PATCHES #60 X 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 Guidelines Salicylate Topicals , Topical Analgesics Lidocaine Page(s): 105 111-112.

**Decision rationale:** The decision for Lidoderm patches quantity 60 x 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical Lidocaine (Lidoderm) 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). No other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**METHADONE 5MG #90 X 2 REFILLS:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guidelines (ODG) Pain, Methadone

**Decision rationale:** The decision for methadone 5 mg quantity 90 x 2 refills is not medically necessary. The Official Disability Guidelines have set up steps for prescribing methadone. The drug should be used with caution in opioid naive patients due to the risk of life threatening hypoventilation. Inform the patient that they should not be tempted to take more methadone than prescribed due to the dangerous buildup that can lead to death. The patient should be warned not to use alcohol, benzodiazepines, or other CNS depressants. Inform the patient of the potential adverse side effects of methadone. The request does not indicate a frequency for the medication. The efficacy for this medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**PERCOCET 5/325MG #30 X 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 Guidelines Percocet, Ongoing Management Page(s): 75, 86 78.

**Decision rationale:** The decision for Percocet 5/325 mg quantity 30 x 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Oxycodone/ Acetaminophen (Percocet) for moderate to severe chronic pain, and that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of

daily living, adverse side effects, and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mg oral morphine equivalents per day. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The 4 A's for ongoing monitoring of an opioid medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**GABAPENTIN 300MG X 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  
Gabapentin Page(s): 16.

**Decision rationale:** The decision for gabapentin 300 mg x 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.