

Case Number:	CM14-0218148		
Date Assigned:	01/07/2015	Date of Injury:	06/17/2003
Decision Date:	03/09/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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: California
 Certification(s)/Specialty: Internal 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 68 year-old male, who was injured on June 17, 2003, while performing regular work duties. The mechanism of injury is due to a fall off of an eight foot high tower, causing injury to the right hand in an attempt to break the fall. The injured worker has had continued complaint of pain of the right mid-back area with radiation to the posterior chest wall and right hip. On December 10, 2014, the injured worker was evaluated reports to have increased pain of the low back with radiation to the right hip, increased muscle spasm and stiffness of the low back and neck. The physical findings reveal sub-occipital/occipital tenderness, tenderness of the thoracic/lumbar region. The injured worker has received treatment including medications, massage, radiofrequency lesioning, right sided facet joint injections, and chiropractic treatment. The request for authorization is for Lidoderm Patch 5%, quantity #30 with two (2) refills; Voltaren Gel 1%, with two (2) refills; Percocet 10/325 mg, quantity #120; Percocet 10/325 mg, quantity #120; Lyrica 100 mg, quantity #90; and Physical therapy, four visits for the thoracic and lumbar spine. The primary diagnoses are chronic pain syndrome, thoracic spondylosis without myelopathy; cervical spondylosis without myelopathy; lumbosacral spondylosis without myelopathy; displacement of cervical intervertebral disc without myelopathy; and obesity. On December 23, 2014, Utilization Review non-certified Lidoderm Patch 5%, quantity #30 with two (2) refills; Voltaren Gel 1% with two (2) refills; Percocet 10/325 mg, quantity #120; Percocet 10/325 mg, quantity #120; Lyrica 100 mg, quantity #90; and physical therapy for one visit, based on MTUS, Chronic pain, and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page 56-57. Topical Analgesics Pages 111-112..

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that Lidoderm is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend Lidoderm for chronic neuropathic pain disorders other than post-herpetic neuralgia. Lidoderm (Lidocaine patch 5%) is not recommended for non-neuropathic pain. Medical records do not document a diagnosis of post-herpetic neuralgia. Per MTUS guidelines, Lidoderm is only FDA approved for post-herpetic neuralgia, and is not recommended for other chronic neuropathic pain disorders or non-neuropathic pain. The medical records do not document a trial of first-line therapy (tri-cyclic or serotonin and norepinephrine reuptake inhibitors anti-depressants or an antiepilepsy drug such as Gabapentin or Lyrica). Medical records and MTUS guidelines do not support the medical necessity of Lidoderm patch. Therefore, the request for Lidoderm patch 5% is not medically necessary.

Voltaren gel 1% with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Pages 111-113. NSAIDs (non-steroidal anti-inflammatory drugs) Pages 67-73..

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials of topical NSAIDs has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be either not superior to placebo after two weeks, or with a diminishing effect after two weeks. For osteoarthritis of the knee, topical NSAID effect appeared to diminish over time. There are no long-term studies of their effectiveness or safety for chronic musculoskeletal pain. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. MTUS Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events,

including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Medical records indicate the long-term use of NSAIDs. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. The progress report dated December 20, 2014 documented a history of myocardial infarction and coronary stent placement. Per MTUS, NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction. Medical records indicate long-term NSAID use, which is not recommended by MTUS. The medical records and MTUS guidelines do not support the use of the topical NSAID Voltaren. The use of the NSAID Voltaren is not supported by MTUS guidelines. Therefore, the request for Voltaren gel 1% is not medically necessary.

Percocet 10/325 mg #120 (do not fill before 12/19/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96. Oxycodone/Acetaminophen (Percocet) Page 92.. Decision based on Non-MTUS Citation FDA Prescribing Information Percocet <http://www.drugs.com/pro/percocet.html>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of breakthrough medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Percocet should be administered every 4 to 6 hours as needed for pain. For more severe pain the dose (based on Oxycodone) is 10-30mg every 4 to 6 hours prn pain. FDA guidelines document that Percocet is indicated for the relief of moderate to moderately severe pain. The progress report dated December 20, 2014 documented cervical, thoracic, and lumbosacral spine disorders. Medical records documented objective evidence of pathology on MRI magnetic resonance imaging studies. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. No adverse side effects were reported. Analgesia was documented. Evaluation for aberrant behavior was documented. Activities of daily living were addressed. Per MTUS, Percocet is indicated for pain. Per FDA, Percocet is indicated for the relief of moderate to moderately severe pain. The medical records provide support for the use of Percocet. The request for Percocet 10/325 mg is supported by the medical records and MTUS and FDA guidelines. Therefore, the request for Percocet 10/325 mg #120 is medically necessary.

Percocet 10/325 mg #120 (do not fill before 1/18/2015): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96. Oxycodone/Acetaminophen (Percocet) Page 92.. Decision based on Non-MTUS Citation FDA Prescribing Information Percocet <http://www.drugs.com/pro/percocet.html>

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Lyrica 100 mg #90: 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 Antiepilepsy drugs (AEDS) page 16-20. Pregabalin (Lyrica) pages 19-20.. Decision based on Non-MTUS Citation FDA Prescribing Information Lyrica http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/021446s026,022488s0051bl.pdf

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that Lyrica (Pregabalin) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. The progress report dated December 20, 2014 do not document the diagnosis of diabetic neuropathy, postherpetic neuralgia, fibromyalgia. Per FDA guidelines, the indications

for Lyrica are diabetic peripheral, post-herpetic neuralgia, partial onset seizures, and fibromyalgia. Per MTUS, a recent review has indicated that there is insufficient evidence to recommend for antiepileptic drugs for axial low back pain. The request for Lyrica is not supported by MTUS guidelines. Therefore, the request for Lyrica 100 mg #90 is not medically necessary.

Physical therapy x4 (thoracic/lumbar): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Pain (Chronic) Physical medicine treatment. Preface, Physical Therapy Guidelines. Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (PT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) recommend 10 visits over eight weeks for lumbar sprains and strains. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six-visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. The progress report dated December 20, 2014 the performance of radiofrequency lesioning on October 8, 2014. Objective findings were document on physical examination and imaging studies. Past chiropractic and massage therapy was reported by the patient to be helpful. Documented past treatments included medications, chiropractor treatment, massage therapy, and trigger point injections. Past physical therapy was not noted. The request for 4 physical therapy PT treatments for the thoracic and lumbar back is supported by MTUS and ODG guidelines. Therefore, the request for 4 physical therapy visits is medically necessary.