

<b>Case Number:</b>	CM15-0122238		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	06/17/2003
<b>Decision Date:</b>	09/17/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2015

### 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 66 year old male patient who sustained an industrial injury on 06/17/2003. A pain management follow up visit dated 06/01/2015 reported chief complaints of having right posterior rib pain mid and lower thoracic spine pain; recent myocardial infarction, and lumbar spine pain. The patient has a cardiac history with previous catheterization and stenting covered with Clopidogrel. He states that the Lidoderm patches do help with this pain, but it is no longer covered. He states using the Voltaren gel along with a pinch of Cannabis between check and gums before bed to assist with sleep. Previous treatment to involve: radiofrequency ablation right T5, 6, 7, 8 facet nerves that produced an 80% pain reduction lasting greater than 3 months. He also had radiofrequency ablation below the above mention levels which produced greater than a 50% deduction in pain. The patient has also participated in chiropractic care, massage therapy, and trigger point injections and trialed the following: Motrin, ASA EC, Lyrica, BenGay, Flector patch, Celebrex, and Lidoderm. The following diagnoses were applied: chronic pain syndrome; thoracic spondylosis without myelopathy; cervical spondylosis without myelopathy; lumbosacral spondylosis without myelopathy, displacement of cervical intervertebral disc without myelopathy and obesity. The plan of care noted the initiation of tapering off Percocet, prescribed to undergo a home based functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CBT x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Behavioral Interventions.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also state that psychological intervention includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. There should be an initial trial of 3-4 visits of psychotherapy over 2 weeks to determine if there is functional improvement. With evidence of objective functional improvement, recommended number of visits is a total of up to 6-10 visits over 5-6 weeks. In this case the request is for six visits. This surpasses the recommended 3-4 over 2 weeks to determine if there is functional improvement. The request is not medically necessary.

**Lidoderm Patch 5% #30 with 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 Pain Interventions and Guidelines Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 anti-epileptic 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 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. Capsaicin is recommended only as an option in patients who have not responded or cannot tolerate other treatments. It is recommended for osteoarthritis, fibromyalgia, and chronic non-specific back pain and is considered experimental in high doses. In this case the patient has been using Lidoderm patches since at least December 2014 and has not obtained analgesia. Criteria for use of lidoderm patches have not been met. The request is not medically necessary.

**Voltaren Gel 1% with 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 Pain Interventions and Guidelines Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac.

**Decision rationale:** Voltaren gel is the topical non-steroidal anti-inflammatory drug (NSAID) diclofenac. Topical NSAIDs have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case documentation in the medical record does not support the diagnosis of osteoarthritis. There is no medical indication for the use of topical diclofenac. The request is not medically necessary.

**Decrease Percocet 10/325 #110 with 1 refill:** 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 Pain Interventions and Guidelines Page(s): 11, 74-96.

**Decision rationale:** Percocet 10/325 is compounded medication containing oxycodone/acetaminophen. 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 or function. It is recommended for short-term use if first-line options,

such as acetaminophen or NSAIDS have failed. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long-term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient has been receiving Percocet since at least and has not obtained analgesia. In addition there is no documentation that the patient has been using Cannabis with the opioid medication. Criteria for long-term opioid use have not been met. The request is not medically necessary.

**Lyrica 150mg #60 with 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 Pain Interventions and Guidelines Page(s): 19-20.

**Decision rationale:** Lyrica is pregabalin, an anti-epilepsy drug. It 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 has been associated with many side effects including edema, CNS depression, weight gain, and blurred vision. Somnolence and dizziness have been reported to be the most common side effects related to tolerability. It is recommended in neuropathic pain conditions and fibromyalgia. In this case there is no documentation in the medical record to support the diagnosis of neuropathic pain or fibromyalgia. In addition the patient has been taking the medication since December 2014 and has not obtained symptoms relief. Lyrica is not medically indicated. The request is not medically necessary.