

<b>Case Number:</b>	CM13-0048529		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	01/31/1999
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### 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 and Rehabilitation, 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:

This male sustained an injury on 1/31/99 while employed by the [REDACTED]. Requests under consideration include Lidoderm Patches 5%, #60, Norco 10/325 Mg, #240, Restoril 30 Mg, #120, Biofreeze Gel #30, And Prilosec 20 Mg, #120. Report of 10/10/13 from the provider noted patient continues with neck pain as has been using Lidoderm patches which helps. He walks and does stationary bike on a regular basis. The patient is doing well on current medication regime. Objective findings documented "No change" without any specific findings or notation. Report of 6/20/13 had exam findings of tenderness to the lumbar and cervical paraspinal muscles with decreased range of motion. Diagnoses list Post laminectomy syndrome with minimal chronic low back pain; interscapular thoracic pain with some radicular features; chronic neck pain, left upper extremity pain with multi-level degenerative disc changes and foraminal stenosis. Report on 10/11/12 list same medications with objective findings of "No significant change." Requests for the above medications were non-certified on 10/29/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LIDODERM PATCHES 5%, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, COMPOUNDED.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL MEDICATIONS Page(s): 111-113.

**Decision rationale:** The patient exhibits diffuse tenderness and pain on the exam to the spine and extremities with some radiation. The chance of any type of patch improving generalized symptoms and functionality significantly with such diffuse pain is very unlikely. Topical Lidoderm patch is indicated for post-herpetic neuralgia, according to the manufacturer. There is no evidence in any of the medical records that this patient has a neuropathic source for the diffuse pain. Without documentation of clear localized, peripheral pain to support treatment with Lidoderm along with functional benefit from treatment already rendered, medical necessity has not been established. There is no documentation of intolerance to oral medication as the patient is also on multiple other oral analgesics. Lidoderm 5% patches #60 is not medically necessary and appropriate.

**NORCO 10/325 MG, #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. NORCO 10/325 MG, #240 is not medically necessary and appropriate.

**RESTORIL 30 MG, #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

**Decision rationale:** Restoril is a benzodiazepine hypnotic often prescribed for the treatment of anxiety/ insomnia. Per the MTUS Chronic Pain Treatment Guidelines, chronic benzodiazepines are the treatment of choice in very few conditions with tolerance to hypnotic effects developing rapidly with anxiolytic effects occurring within months; limiting its use to 4 weeks as long-term use may actually increase anxiety. Submitted reports have not demonstrated any clinical findings or specific sleep issues such as number of hours of sleep, difficulty getting to sleep or staying asleep or how use of this sedative/hypnotic has provided any functional improvement from treatment already rendered. The RESTORIL 30 MG, #120 is not medically necessary and appropriate.

**BIOFREEZE GEL #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, COMPOUNDED.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

**Decision rationale:** Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. There is no information or clarification provided as to how it is medically necessary to treat this injured worker who is not intolerable to oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. The BIOFREEZE GEL #30 is not medically necessary and appropriate.

**PRILOSEC 20 MG, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

**Decision rationale:** This medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec) namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The PRILOSEC 20 MG, #120 is not medically necessary and appropriate.