

<b>Case Number:</b>	CM14-0014576		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	11/12/2007
<b>Decision Date:</b>	12/23/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 Family Practice 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:

34 yr. old male claimant sustained a cumulative work injury from 6/06-11/07 involving the low back. He was diagnosed with lumbar disc disease. An MRI in 2013 showed L4-L5 disc protrusions and facet hypertrophy. A progress note on 1/7/14 indicated the claimant had lumbar tenderness bilaterally, reduced range of motion and a positive straight leg raise test bilaterally. Sensation was decreased bilaterally in the L5 dermatomes. The claimant was treated with Anaprox, Norco, Oxycontin, Prilosec, Soma, Ambien, Lidoderm Patch, Anaprox, topical Dendracin, Zanaflex and Roxicodone. A progress note on 11/4/14 indicated the claimant had 8-10 pain on the current medication regimen. Exam findings were essentially unchanged. The claimant was continued on the above medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS 550mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67.

**Decision rationale:** According to the guidelines, NSAIDs are recommended as 2nd line to Tylenol for acute exacerbations of chronic back pain. They are recommended for short-term for chronic back pain. In this case, the claimant had been on Anaprox for over 10 months along with opioids without change in pain or function. The continued use of Anaprox is not medically necessary.

**Soma 350mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 39.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

**Decision rationale:** According to the MTUS guidelines, Soma is not recommended. Soma is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Abuse has been noted for sedative and relaxant effects. As a combination with hydrocodone, an effect that some abusers claim is similar to heroin. In this case, it was combined with hydrocodone which increases side effect risks and abuse potential. The claimant had been on Soma for over 10 months along with opioids without change in pain or function. The use of Soma is not medically necessary.

**Ambien CR 12.5mg, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/ Disability Duration Guidelines, Stress & Mental Illness Chapter Zolpidem

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

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was not defined or further evaluated. Continued use of Ambien CR is not medically necessary.

**Lidoderm 5% patch, #30:** 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 Page(s): 111-112.

**Decision rationale:** According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They 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. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI (serotonin-norepinephrine reuptake inhibitor) anti-depressants or an AED (antiepilepsy drug) such as gabapentin or Lyrica). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. In this case the claimant did not have the above diagnoses. Long-term use of topical analgesics, such as Lidoderm patches, is not recommended. The request for continued and long-term use of Lidoderm patches as above is not medically necessary.

**Dendracin topical (dose and frequency unknown):** 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 Page(s): 111-112.

**Decision rationale:** According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Dendracin contains: Methyl Salicylate 30%, Capsaicin 0.0375%. According to the guidelines: Capsaicin, topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. In this case, the Capsaicin quantity in Dendracin exceeds the amount recommended by the guidelines. Any compounded that is not recommended is not recommended for the entire topical formulation. In addition, Dendracin had been used for over 10 months without improvement in pain scale or function. Topical Dendracin is not medically necessary.