

<b>Case Number:</b>	CM14-0016328		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	02/05/2002
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Texas. 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 an 83-year-old male who reported an injury on 02/05/2002 after a fall. The injured worker's treatment history included 2 level fusion in the lumbar spine, injections to the left knee. The injured worker's chronic pain was managed by multiple medications to include Norco, Soma, Neurontin, Lidoderm patches, Mobic, Nizatidine, and Cidaflex. The injured worker was evaluated on 01/15/2014. It was documented that the injured worker had pain rated at a 10/10 that was reduced to a 7/10 with medication usage. It was documented that the injured worker could self manage any side effects related to medication usage. Physical findings included restricted lumbar range of motion secondary to pain with a positive straight leg raising test. The injured worker's diagnoses included right lumbar radiculopathy status postsurgical intervention, left knee strain with medial meniscus tear, gastrointestinal upset related to medication usage, insomnia related to chronic pain, and atrophy of left quadriceps. The injured worker's treatment plan included continuation of medications, a back brace, and continuation of a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 PRESCRIPTION OF SOMA 350MG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The requested prescription of Soma 350 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants for short term treatment of acute exacerbations of pain. The clinical documentation submitted for review does not indicate that the injured worker is experiencing an acute exacerbation. Additionally, the clinical documentation does support that the injured worker has been taking this medication since at least 05/2013. As it appears, this medication is being used to manage the injured worker's chronic pain; continued use would not be supported. Also, the request as it is submitted does not include a quantity or frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested prescription of Soma 350 mg is not medically necessary or appropriate.

**1 PRESCRIPTION OF NEURONTIN 300MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain And Anti-Epilepsy Drugs Page(s): 16.

**Decision rationale:** The requested prescription of Neurontin 300 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of anticonvulsants as a first line medication in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends the ongoing use of any medication to managing an injured worker's chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation does indicate that the injured worker has 10/10 pain that is reduced to a 7/10 with medications. However, there is no documentation of functional benefit to support continued use of this medication. Additionally, the request as it is submitted does not provide a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the prescription of Neurontin 300 mg is not medically necessary or appropriate.

**1 PRESCRIPTION OF CELEBREX 100MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 60, 67.

**Decision rationale:** The requested prescription of Celebrex 100 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, California Medical Treatment Utilization Schedule also states that ongoing use of medications to treat

chronic pain must be supported by documentation of functional benefit and pain relief. The clinical documentation does indicate that the injured worker has 10/10 pain that is reduced to a 7/10 with medications. However, there is no documentation of functional benefit to support continued use. Also, the request as submitted does not clearly identify a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested prescription of Celebrex 100 mg is not medically necessary or appropriate.

**1 PRESCRIPTION OF TOPICAL COMPOUND DICLOFENAC 15%/ GABAPENTIN 10%/ LIDOCAINE 10%: 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.

**Decision rationale:** The requested prescription of topical compound Diclofenac 15%, Gabapentin 10% and Lidocaine 10% is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of topical nonsteroidal anti-inflammatory drugs unless oral formulations are not well tolerated by the injured worker or when oral formulations are contraindicated for injured worker. The clinical documentation submitted for review does not provide any evidence that the injured worker cannot tolerate oral formulations of this medication. Therefore, a topical formulation will not be supported. Additionally, California Medical Treatment Utilization Schedule does not support the use of Gabapentin in a topical formulation as there is little scientific evidence to support the efficacy and safety of this medication. Also, California Medical Treatment Utilization Schedule does not recommend the use Lidocaine in a cream or gel formulation as it is not FDA approved to treat neuropathic pain. California Medical Treatment Utilization Schedule does not support the use of any medication that contains at least 1 drug or drug class that is not recommended by guideline recommendations. Additionally, the request as it is submitted does not provide a quantity, frequency or body part of which the medication should be applied. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested prescription of topical compound Diclofenac 15%/Gabapentin 10%/ Lidocaine 10% is not medically necessary or appropriate.