

<b>Case Number:</b>	CM14-0112570		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/18/2002
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma. 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 a 53-year-old female who reported an injury on 09/18/2002 due to an unknown mechanism. Diagnoses were displacement disc site, unspecified, without myelopathy; brachial neuritis/radiculitis; neck sprain and strain. Physical examination on 05/14/2014 remains unchanged, remains symptomatic. Examination revealed pain to palpation in the cervical spine and lumbar spine. There was decreased range of motion in both cervical spine and lumbar spine due to pain. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

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

**Decision rationale:** The decision for Anaprox DS 550 mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that lowest effective dose be used for all non-steroidal anti-inflammatory drugs (NSAIDs) for the

shortest duration of time consistent with individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The efficacy of this medication was not reported. There was no documentation of objective functional improvement and objective decrease in pain. The request does not indicate a frequency for the medication. The clinical documentation submitted for review does not provide evidence that this medication is providing functional improvement. Therefore, this request is not medically necessary.

**LidoPro 121 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical salicylate Page(s): 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Salicylate Topicals, Topical Analgesics, Topical capsaicin, Lidocaine Page(s): 105, 11.

**Decision rationale:** The decision for Lidopro 121 mg is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin 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. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per drugs.com, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There were no significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**Roxicodin 30 mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

**Decision rationale:** The decision for Roxycodone 30 mg #240 is not medically necessary. The California Medical Treatment Utilization Schedule guidelines recommend the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior be documented. The efficacy of this medication was not reported. The request

does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.