

<b>Case Number:</b>	CM14-0025217		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	01/08/2003
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 62-year-old male with a reported injury on 01/08/2013. The diagnosis was low back pain. The documentation from early 2013 revealed the injured worker was utilizing Lidoderm 5% adhesive patches 1 patch 12 hours on 12 hours off, Celebrex 200 mg capsules 1 capsule 1 to 2 times a day, Soma 350 mg tablets 1 by mouth twice a day, Lunesta 3 mg tablets 1 at bedtime, Norco 10/325 tablets 1 to 2 tablets 2 times a day as needed, Dexilant, fish oil, tamsulosin hydrochloride 0.4 mg capsules, Tylenol PM, VESicare 10 mg tablets, amlodipine, Flector, Tylenol extra strength, vitamin C 1000 mg tablets and vitamin 400 IU capsules. The documentation from 02/14/2014 showed that the injured worker had chronic low back pain and was stable with no changes since the last visit. The injured worker had pain over the bilateral lumbar paraspinal muscles. The diagnosis was low back pain. The treatment plan included Celebrex for anti-inflammatory effect and Norco 10/325 for pain. The prescriptions additionally included Lunesta 3 mg tablets 1 pill at bedtime #30 tablets with 2 refills, Celebrex 200 mg capsules 1 capsule 1 to 2 times a day #60 with 2 refills, Norco 10/325 mg tablets 2 times a day as needed with 2 refills, Lidoderm 5% adhesive patches apply every 12 hours refill times 2, and Norflex 100 mg tablets 1 pill twice a day refills times 2, as well as Lyrica 75 mg capsules 1 capsule by mouth twice a day with 2 refills. The prior treatments were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ORPHENADRINE CITRATE ER 100MG # 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 9 months. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for orphenadrine citrate ER 100mg #60 is not medically necessary.

**CELEBREX 200 MG # 60:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend NSAIDs for the short term symptomatic treatment of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 9 months. There was a lack of documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating a necessity for a topical NSAID and an oral NSAID as it was indicated the injured worker's medication that was being reviewed as well included Flector patches. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Celebrex 200 mg quantity 60 is not medically necessary.

**HYDROCODONE/ACETAMINOPHEN 10/325 MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use For A Therapeutic Trial Of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 60, 78.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review

indicated the injured worker had been utilizing the medication for greater than 9 months. There was a lack of documentation of the above criteria. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for hydrocodone/acetaminophen 10/325mg # 120 is not medically necessary.

**LIDODERM PATCH 5% # 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 Lidoderm Page(s): 56, 57.

**Decision rationale:** The Chronic Pain Medical Treatment 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide the efficacy for the requested medication. The clinical documentation indicated the injured worker had been utilizing the medication for greater than 9 months. The efficacy was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Lidoderm patch 5% # 30 is not medically necessary.

**FLECTOR PATCH 1.3% # 60: 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 Anesthetics, Topical NSAIDS Page(s): 111-112.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. The clinical documentation submitted for review failed to provide documented rationale for the necessity of the medication. The clinical documentation submitted for review indicated the

injured worker had been utilizing the medication for greater than 9 months. There was a lack of documentation per the submitted request for the frequency for the requested medication. Given the above, the request for Flector patch 1.3% quantity 60 is not medically necessary.

**LUNESTA 3MG # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther. 2005 Feb. 28;47 (1203); 13-9, Eszopiclone.

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

**Decision rationale:** The ODG indicates that Lunesta is not recommended for long term use; however, it is recommended for the short term use. The clinical documentation submitted for review failed to provide efficacy for the requested medication. The clinical documentation indicated the injured worker had been utilizing the medication for greater than 9 months. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Lunesta 3mg # 30 is not medically necessary.