

<b>Case Number:</b>	CM14-0054825		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	06/14/2000
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 Occupational Medicine, 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 is a 46-year-old male with a 6/14/00 date of injury. The mechanism of injury was not noted. According to a 5/21/14 progress report, the patient had multiple orthopedic complaints. Objective findings: cervical spine spasm, painful, decreased ROM, facet tenderness, radiculopathy bilaterally at C5-7; positive Phalen and Darkin compression of right wrist; lumbar spine spasm, painful and limited ROM, positive straight leg raise bilaterally to 60 degrees. Diagnostic compression: status post left knee surgery, left knee recurrent internal derangement, right knee sprain/strain, lumbar discogenic disease with radiculitis, chronic cervical spine sprain/ankle, cervical discogenic disease, cervical facet syndrome. Treatment to date: medication management, activity modification, TENS unit, physical therapy. A UR decision dated 3/26/14 denied the requests for Norco, Anaprox DS, and LKG/Caps Cream. The specific rationales for denial were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 325; 10mg 4 times per day for 30 days:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 page(s) 78-81 Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Norco 325 mg; 10 mg 4 times per day for 30 days is not medically necessary.

**Anaprox DS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 page 67 Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDS.

**Decision rationale:** CA MTUS states that NSAIDs are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. In addition, ODG states that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. It is documented in a 5/21/14 progress report that Anaprox DS helps the patient's pain and inflammation. Guidelines support the use of NSAIDs with documentation of functional improvement. However, the quantity of medication requested was not provided in this request. Therefore, the request for Anaprox DS, as submitted, is not medically necessary.

**LKG/Caps Cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 page(s) 25, 28, 111-113 Page(s): 25, 28, 111-113.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, Baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. After an extensive online search, the active ingredients of LKG/caps cream could not be identified. The medical necessity of this product could not be determined due to the

lack of information regarding its ingredients. Therefore, the request for LKG/Caps cream is not necessary.