

<b>Case Number:</b>	CM15-0190872		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	11/30/1995
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

### 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 68 year old male who sustained an industrial injury November 30, 1995. According to a supplemental pain management progress report dated September 11, 2015, the injured worker presented for his chronic low back pain which radiates down the lateral aspect of his lower extremity to the knee. He is still undergoing chiropractic therapy. With chiropractic therapy and medication he reports over a 50% improvement in functional ability and an edge off the pain. He has been purchasing Biofreeze out of pocket. Current medication included Duragesic, Lunesta, Neurontin, Oxycodone, and Biofreeze Gel. Physical examination revealed; 6'2" and 280 pounds; lumbar spine; straight leg raise left and right normal at 90 degrees pain over the lumbar intervertebral spaces (discs) on palpation, mild palpable twitch, positive trigger points lumbar paraspinal muscles; gait normal; pain with lumbar extension; left hip- very painful in abduction, flexion, and extension Patrick's negative right positive left; motor strength is grossly normal except right lower extremity extension and flexion with resistance; lower extremity sensation intact except for left lateral thigh. Diagnoses are lumbosacral radiculopathy; lumbar spine pain; lumbar degenerative disc disease; lumbar, failed back syndrome. The physician documented the injured worker is compliant with medication and has a signed pain agreement on file with monitoring of CURES reports and urine drug screens. At issue, is a request for authorization for Biofreeze and Duragesic. According to utilization review dated September 21, 2015, the request for Oxycodone 10mg Quantity:90 was certified. The request for Duragesic 25mcg Quantity: 15 were modified to Duragesic 25mcg Quantity: 10. The request for Biofreeze Gel 32 oz. Quantity: (1) was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Duragesic 25mcg, quantity: 15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)

The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication.. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**Biofreeze gel 32oz, quantity: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. 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. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients, which are not indicated per the California MTUS for topical analgesic use. Therefore the request is not medically necessary.

