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| <b>Case Number:</b>   | CM14-0162210 |                              |            |
| <b>Date Assigned:</b> | 10/07/2014   | <b>Date of Injury:</b>       | 09/11/2008 |
| <b>Decision Date:</b> | 12/17/2014   | <b>UR Denial Date:</b>       | 09/22/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/02/2014 |

### 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 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 59-year-old female patient who reported an industrial injury to the back on 9/11/2008, over six (6) years ago, attributed to the performance of her usual and customary job tasks. The patient complains of persistent lower back pain and left shoulder pain. The patient reports decreased pain with the prescribed medications. The objective findings on examination included "no significant changes; equal and symmetrical DTRs to the bilateral lower extremities; no upper tract findings; lumbar spine range of motion limited in both flexion and extension." The patient is being prescribed Norco 5/325 mg; Norco 10/325 mg; Gabapentin; Biofreeze; Relafen 750 mg; Robaxin 750 mg; and Lidoderm patches. The treating diagnoses is left greater than right shoulder pain s/p right shoulder arthroscopy with acromioplasty in Mumford on 10/29/2013, and lower back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Neurontin 100 mg #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter

revised 8/8/08 page 110 and on the Official Disability Guidelines (ODG) pain chapter- medications for chronic pain; anti-epilepsy drugs

**Decision rationale:** The provider has prescribed Gabapentin (Neurontin) 100 mg #180 and there is no reported neuropathic pain issue. There is no documented Electrodiagnostic evidence of a nerve impingement radiculopathy. There is no demonstrated neurological deficit along a dermatomal distribution. It is not clear that the patient has neuropathic pain, as there are no documented neurological deficits. The patient is stated to have neuropathic pain for which the patient has been prescribed Gabapentin/Neurontin. The prescription of Gabapentin (Neurontin) was not demonstrated to have been effective for the patient for the chronic pain issues. The provider does not provide objective findings on examination to support the presence of neuropathic pain for the cited diagnoses. The provider has provided this medication for the daily management of this patient's chronic pain. The prescription of Gabapentin (Neurontin) is recommended for neuropathic pain; however, the ACOEM Guidelines. Gabapentin or pregabalin is not recommended for treatment of chronic, non-neuropathic pain by the ACOEM Guidelines. It is clear that there is no documentation of significant neuropathic pain for this patient. The ACOEM Guidelines revised chronic pain chapter states; there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back pain; chronic lower back pain; or chronic lower back pain with radiculopathy. The CA MTUS and the Official Disability Guidelines state, there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain. There is no demonstrated medical necessity for the prescribed Neurontin 100 mg #180.

**Retrospective request for Biofreeze Gel 32 Tubes:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47; 128, Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter topical analgesics, topical analgesics compounded

**Decision rationale:** The dispensed/prescribed Biofreeze Gel 32 tubes are not demonstrated to be medically necessary for the treatment of the patient's chronic shoulder and back pain. There is no demonstrated medical necessity of the concurrent prescription of the Biofreeze as opposed to the available OTC topical remedies. There is no provided subjective/objective evidence provided to support the medical necessity of the Biofreeze applied to the affected areas over six (6) years after the date of injury as opposed to the readily available OTC topical analgesics. The use of the topical creams does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of creams on areas that are not precise. The volume applied and the times per day that the creams are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of creams to the oral medications in the same drug classes. There is no demonstrated evidence that the topicals are more effective than generic oral medications. There is no provided medical evidence that the prescription of Biofreeze is medically necessary.

