

<b>Case Number:</b>	CM15-0015023		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	09/11/2008
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 59 year old female, who sustained an industrial injury on 9/11/2008. She has reported left shoulder injury. The diagnoses have included shoulder pain status post operative fixation times 2 on the left, status post right shoulder arthroscopy on 10/29/13 and low back pain. Treatment to date has included medications, Home Exercise Program (HEP), cortisone injections, diagnostics, surgery and physical therapy. Currently, the injured worker complains of continued left shoulder and low back pain status post surgical intervention. She was diagnosed with left rotator cuff impingement and received a cortisone injection with some relief. She has also received physical therapy sessions. There are no further tests or recommendations other than physical therapy at this time. The pain is rated 6/10 with her medications but right now she complains of a cold and not feeling well. She states that usually the medications bring the pain to 4-5/10. The last urine drug screen was consistent. Request re-fills of medications and follows up in 2 months. On 1/13/15 Utilization Review non-certified a request for Norco 5/325mg #30, Norco 10/325mg #60 DND, Norco 5/325mg #30 DND 01/29/2015, Norco 10/325mg #60, Lidoderm patch 5% #30 with 5 refills, Gabapentin 100mg TID #90 with 1 refill, and Retro Biofreeze #2, noting that they were not medically necessary. There were no official guidelines cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325mg #30:** 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has by far exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician documents the least reported pain over the period since last assessment, intensity of pain after taking opioid and increased level of function (walking one mile). However there is no documentation of side effects, no documentation of failed therapies that have required the use of longterm opioids or indications why the use of opioids should be considered beyond recommended guidelines. Given the duration of therapy with opioids this IW should be considered for weaning therapy to allow for minimization of withdrawal symptoms As such, the request for Norco 325/5 mg is deemed not medically necessary.

**Norco 10/325mg #60 DND:** 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has by far exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician documents the least reported pain over the period since last assessment, intensity of pain after

taking opioid and increased level of function (walking one mile). However there is no documentation of side effects, no documentation of failed therapies that have required the use of longterm opioids or indications why the use of opioids should be considered beyond recommended guidelines. Given the duration of therapy with opioids this IW should be considered for weaning therapy to allow for minimization of withdrawal symptoms As such, the request for Norco 325/10 mg is deemed not medically necessary.

**Norco 5/325mg #30 DND 01/29/2015: 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has by far exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician documents the least reported pain over the period since last assessment, intensity of pain after taking opioid and increased level of function (walking one mile). However there is no documentation of side effects, no documentation of failed therapies that have required the use of longterm opioids or indications why the use of opioids should be considered beyond recommended guidelines. Given the duration of therapy with opioids this IW should be considered for weaning therapy to allow for minimization of withdrawal symptoms As such, the request for Norco 325/5 mg is deemed not medically necessary.

**Norco 10/325mg #60: 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has by far exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation

of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician documents the least reported pain over the period since last assessment, intensity of pain after taking opioid and increased level of function (walking one mile). However there is no documentation of side effects, no documentation of failed therapies that have required the use of longterm opioids or indications why the use of opioids should be considered beyond recommended guidelines. Given the duration of therapy with opioids this IW should be considered for weaning therapy to allow for minimization of withdrawal symptoms As such, the request for Norco 325/10 mg is deemed not medically necessary.

**Lidoderm patch 5% #30 with 5 refills:** 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 lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Pain, Topical analgesics UpToDate.com, Lidocaine (topical)

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine 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. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics."ODG further details, "Criteria for use of Lidoderm patches:(a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day).(f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued."Medical documents provided do not

indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail first-line therapy failures and in fact the use of gabapentin is ongoing. As such, the request for Lidoderm 5% patches is deemed not medically necessary.

**Gabapentin 100mg TID #90 with 1 refill: Overturned**

**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 Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin

**Decision rationale:** The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. ODG also states that Gabapentin "has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." There is no documentation of a prior trial, but given the very low dosage being utilized (100mg TID) in this case it must be assumed that the trial is ongoing and the medication is titrating up. Based on the clinical documentation provided, there is evidence of neuropathic type pain subjectively. As such, I am reversing the prior decision and deem the request for gabapentin 100 mg to be medically necessary.

**Retro Biofreeze #2: 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 Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Pain (Chronic) and Low Back, Topical Analgesics and Biofreeze

**Decision rationale:** Biofreeze is a compound topical analgesic containing camphor and menthol. ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "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." ACOEM and MTUS are silent regarding the use of camphor. ODG states in the low back chapter regarding biofreeze, "recommended as an optional form of cryotherapy for acute (not chronic) pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs

only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)." Medical documents do not indicate that the Biofreeze is to be used for acute low back pain and, as noted above, there is no documentation of failure of antidepressants or anticonvulsants (anticonvulsant therapy is ongoing). As such, the request for Biofreeze gel is deemed to be not medically necessary.