

<b>Case Number:</b>	CM13-0035332		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	12/28/2007
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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, has a subspecialty in Pain Medicine and Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a work injury with a date of injury 12/28/07. She is being treated for a primary diagnosis of generalized osteoarthritis. She was seen by the requesting provider on 08/09/13. The assessment references an injury as occurring in January 2005. She was having constant neck pain, back pain, left knee pain with tingling, and numbness and tingling of the left foot. Pain was aggravated by standing and walking. She was applying for a job as a Ward Clerk. Physical examination findings included decreased cervical spine range of motion with trapezius muscle and cervical paraspinal muscle tenderness with spasm. There was decreased thoracolumbar spine range of motion with muscle spasm. There was a left knee effusion and tenderness. There was decreased left lower extremity sensation. Diagnoses were osteoarthritis, tennis elbow, and internal knee derangement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF VOLTAREN XR 100MG #60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 67-71.

**Decision rationale:** The requesting provider documents that she is as applying for a job as a Ward Clerk which would be expected to require a sedentary capacity, likely within her abilities. Guidelines recommend the use of NSAID (nonsteroidal anti-inflammatory medications) with caution as an option in the treatment of chronic pain including pain from osteoarthritis. Dosing is Voltaren-XR 100 mg PO once daily for chronic maintenance therapy. Therefore, the requested Voltaren ER is medically necessary.

**PRESCRIPTION OF VICODIN 5/50MG #60: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): p76-80.

**Decision rationale:** The claimant has a remote history of a work injury occurring more than 15 years ago and continues to be treated for chronic pain with a primary diagnosis of generalized osteoarthritis. The requesting provider documents that she is as applying for a job as a Ward Clerk which would be expected to require a sedentary capacity, likely within her abilities. She appears to have somewhat predictable activity-related breakthrough pain (i.e. incident pain) when standing and walking. She appears motivated with reference to return to work planned. Vicodin is a short-acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. Therefore, the continued prescribing of Vicodin is medically necessary.

**PRESCRIPTION OF FIORICET #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BARBITUATE-CONTAINING ANALGESIC AGENTS (BCAs) Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Assessment Approaches, p6 (2) Barbiturate-containing analgesic agents (BCAs), p23 Page(s): 6; 23.

**Decision rationale:** Whether the claimant actually has headaches is not known and there is no description of location, character, frequency, or duration. Classification of a headache condition cannot be determined. Barbiturate-containing analgesic agents such as Fioricet are not recommended for chronic pain. The Beers criteria for inappropriate medication use include barbiturates. There is a high potential for drug dependence and no evidence to show a clinically important increased analgesic efficacy due to the barbiturate constituents. There is a risk of medication overuse as well as rebound headache. Additionally, in this case, classifying the claimant's headaches would be expected to identify appropriate alternative treatments and

preventative measures and per guidelines the request for Fioricet #60 is not medically necessary and appropriate.

**PRESCRIPTION OF FLURBIPROFEN 25%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, (2) Topical Analgesics Page(s): 60; 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Flurbiprofen Prescribing Information>.

**Decision rationale:** The requesting provider documents that she is as applying for a job as a Ward Clerk which would be expected to require a sedentary capacity, likely within her abilities. Flurbiprofen is a non-steroidal anti-inflammatory (NSAID) medication. Compounded topical preparations of Flurbiprofen are used off-label (non-FDA approved) and have not been shown to be superior to commercially available topical medications such as Diclofenac. Additionally, in this case, Voltaren ER is also being requested which would be duplicative. Guidelines recommend that when prescribing medications only one medication should be given at a time therefore the request for Flurbiprofen 25% is not medical necessary and appropriate.

**PRESCRIPTION OF CYCLOBENZAPRINE 30GM 10% TRAMADOL 10%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, (2) Topical Analgesics Page(s): 60; 111-113.

**Decision rationale:** The claimant has a remote history of a work injury occurring more than 15 years ago and continues to be treated for chronic pain with a primary diagnosis of generalized osteoarthritis. She has left lower extremity radicular symptoms. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical non-steroidal anti-inflammatory medication can be recommended for patients with chronic pain where the target tissue is located superficially. Cyclobenzaprine is a muscle relaxant and there is no evidence for the use of any muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. By prescribing a compounded medication, in addition to increased risk of adverse side effects, it is not possible to determine whether any derived benefit is due to a particular component. Guidelines also recommend that when prescribing medications only one medication should be given at a time therefore the request for Cyclobenzaprine 30gm 10% Tramadol 10% is not medically necessary and appropriate.

**PSYCH FOLLOW-UP: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Occupational Medicine Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, p127.

**Decision rationale:** Guidelines recommend consideration of a consultation if clarification of the situation is necessary. In this case, the claimant has complaints related to the neck, back, and left lower extremity. There is no identified psychiatric condition or complaint and she is not taking any psychoactive medication. The issue needs to be clarified and therefore the request for Psych Follow-up is not medically necessary and appropriate.