

<b>Case Number:</b>	CM13-0050109		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/17/1997
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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 physician 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 patient is a 56-year-old female who reported an injury on 09/17/1997. The mechanism of injury is not specifically stated. The patient was seen by [REDACTED] on 10/08/2013. The patient reported 2/10 pain with medications. Physical examination revealed normal gait and station, decreased sensation to light touch in bilateral upper extremities, decreased range of motion of the cervical spine, diffuse tenderness in the trapezius and infrascapular area, and tenderness to palpation of the thoracic spine. Treatment recommendations included continuation of current medication, including butalbital compound, Celebrex, gabapentin, Gabitril, hydrocodone, lidocaine, omeprazole, and Relpax.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butalbital compound 50/325/40mg, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** Official Disability Guidelines state barbiturate-containing analgesic agents are not recommended for chronic pain. Fioricet is commonly used for acute headache, with

some data to support it, but there is a risk of medication overuse, as well as rebound headache. The potential for drug dependence is high, and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to barbiturate constituents. As per the documentation submitted, the patient has continuously utilized this medication. As guidelines do not recommend the use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**Celebrex 200mg, #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Celebrex is indicated for the relief of signs and symptoms of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis. The patient does not maintain any of the above-mentioned diagnoses for the use of this medication. Despite ongoing use, the patient continues to demonstrate decreased range of motion, tenderness to palpation, and decreased sensation. Additionally, California MTUS Guidelines state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**Gabitril 4mg, #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

**Decision rationale:** California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. As per the documentation submitted, the patient is currently utilizing gabapentin in addition to Gabitril. The medical necessity for 2 separate anti-epilepsy medications has not been established. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**Lidocaine 5%, #60: Upheld**

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Lidocaine is indicated for neuropathic pain and localized peripheral pain after there has been evidence of a trial of first-line therapy with tricyclic or SNRI antidepressants or anticonvulsants. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to demonstrate decreased sensation, decreased range of motion, and diffuse tenderness to palpation. There is also no indication of a failure to respond to first-line oral medication prior to initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.