

<b>Case Number:</b>	CM14-0004978		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	12/13/1996
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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 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 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 injured worker is a 57-year-old female who reported an injury on 12/13/1996 secondary to an unknown mechanism of injury. Her diagnoses include cervical radiculopathy, lumbar radiculopathy, depression, and chronic pain. Her current medications were noted to include Cymbalta 60 mg at bedtime, Seroquel 50 mg twice daily, Neurontin 600 mg 3 times daily, Robaxin 500 mg twice daily, Percocet 10/325 mg every 4 hours, Voltaren 1% gel, and fentanyl 75 mcg/hour patch every 72 hours. The injured worker was evaluated on 12/26/2013 and reported neck pain radiating to the bilateral upper extremities, as well as low back pain radiating to the bilateral lower extremities. She reported that her pain intensity was 9/10 with medications and 10/10 without medications. She also reported that her pain was worsened since her last visit. On physical examination, the injured worker was noted to have myofascial trigger points in the paraspinal region and moderately limited range of motion of the lumbar spine. It was noted that the injured worker was treated previously with activity modifications, physical therapy, and trigger point injections. The injured worker was recommended for renewal of her current medications. The duration of treatment with the injured worker's current medications was not provided. A request for authorization was submitted on 01/03/2014 for Seroquel 50 mg #30, Robaxin 500 mg #30, Voltaren 1% gel #100, Percocet 10/325 mg #90, and fentanyl 75 mcg/hour patch #5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SEROQUEL 50MG #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress, Atypical antipsychotics.

**Decision rationale:** The request for Seroquel 50 mg #30 is non-certified. Seroquel has been FDA approved for the treatment of schizophrenia and bipolar disorder. The Official Disability Guidelines state there is insufficient evidence to recommend an atypical antipsychotic such as Seroquel for treatment of other conditions. The injured worker was noted to have a diagnosis of depression. The medical records submitted for review fail to indicate a diagnosis of schizophrenia or bipolar disorder. There is also lack of documented evidence to indicate the injured worker's treatment duration with Seroquel. There is a lack of documented evidence of objective functional improvement and psychometric testing to indicate functional gains made with the injured worker's use of Seroquel. Therefore, it is unclear that the injured worker would benefit from continued use of Seroquel. As such, the request for Seroquel 50 mg #30 is non-certified.

**ROBAXIN 500MG #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 Muscle relaxants (for pain) Page(s): 63-65.

**Decision rationale:** The request for Robaxin 500 mg #30 is non-certified. The injured worker reported neck pain radiating to the upper extremities bilaterally and low back pain radiating to the lower extremities bilaterally. She rated the pain as 9/10 in intensity with medications and 10/10 without medications. She also reported that her pain was worsened since her last visit. On physical examination, she was noted to have myofascial trigger points in the paraspinal region. The California MTUS Guidelines may recommend muscle relaxants as a second-line option for short-term treatment of acute exacerbations in injured workers with chronic low back pain. The medical records submitted for review failed to indicate the duration of the injured worker's treatment with Robaxin. It was noted that the injured worker reported minimal pain relief of 10% with her current medications. There were no objective functional improvements noted with her medications. There is a lack of documented evidence to indicate that the injured worker has achieved significant pain relief and objective functional improvement with the use of Robaxin. Therefore, it is unclear that the injured worker would benefit from continued use of Robaxin. As such, the request for Robaxin 500 mg #30 is non-certified.

**VOLTAREN 1% GEL #100:** 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): 111-112.

**Decision rationale:** The request for Voltaren 1% gel #100 is non-certified. The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Additionally, the guidelines state that Voltaren gel 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. These guidelines state that Voltaren gel 1% has not been evaluated for treatment of the spine, hip, or shoulder. The injured worker reported neck and back pain. The evidence-based guidelines do not support the intended use of Voltaren gel for the treatment of the injured worker's neck and back pain. She reported that she received 10% pain relief with the use of medications and that her pain had worsened since her last visit. There is insufficient documented evidence to indicate that the injured worker has achieved significant pain relief and objective functional improvement with the use of Voltaren 1% gel. Based on the injured worker's current pain presentation and the lack of significant pain relief and objective functional improvement gained with this medication, the necessity for continued use of Voltaren 1% gel has not been established. As such, the request for Voltaren 1% gel #100 is non-certified.

**PERCOET 10-325 G #90:** 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, criteria for use Page(s): 78.

**Decision rationale:** The request for Percocet 10/325 mg #90 is non-certified. The injured worker reported neck and low back pain radiating to the extremities. She reported a pain intensity of 9/10 with medications which increased to 10/10 without medications. The medical records submitted for review failed to indicate the duration of the injured worker's treatment with Percocet. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects in order to warrant continued opioid use. The injured worker reported only minimal pain relief of 10% with the use of her current medications. There is a lack of documented evidence of objective functional improvement with the use of medications. The documentation submitted for review also fails to provide a recent urine drug screen to monitor for appropriate medication use or potentially aberrant drug-related behavior. Therefore, in the absence of significant pain relief, objective functional improvement, or documentation of appropriate medication use, the necessity of continued use of Percocet has not been established. As such, the request for Percocet 10/325 mg #90 is non-certified.

**FENTANYL 75MEQ/HR PATCH #5:** 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, criteria for use Page(s): 78.

**Decision rationale:** The request for fentanyl 75 mEq/hour patch #5 is non-certified. The injured worker reported neck and low back pain radiating to the extremities. She reported a 9/10 pain intensity with medications and 10/10 intensity without medications. The medical records submitted for review failed to indicate the duration of the injured worker's treatment with fentanyl patches. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects in order to warrant continued opioid use. The most recent clinical note indicates that the injured worker reported only minimal pain relief of 10% with the use of fentanyl. There were no documented objective functional improvements with the use of medications. The documentation submitted for review also failed to provide a recent urine drug screen to monitor for appropriate medication use and potentially aberrant drug-related behavior. Therefore, there is insufficient evidence to indicate that the continued use of fentanyl patches would be supported by the evidence-based guidelines. Furthermore, the request as written is for fentanyl 75 mEq/hour. The guidelines state that weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl. The guidelines also state that fentanyl is an opioid analgesic with a potency 80 times that of morphine. Fentanyl is usually ordered in mcg/hour. It is unclear that the request for fentanyl 75 mEq/hour meets standard safety guidelines for fentanyl dosing. Based on the lack of significant pain relief, objective functional improvement, or recent urine drug screens, there is insufficient evidence to support the continued use of fentanyl. As such, the request for fentanyl 75 mEq/hour patch #5 is non-certified.