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| <b>Case Number:</b>   | CM14-0086524 |                              |            |
| <b>Date Assigned:</b> | 07/23/2014   | <b>Date of Injury:</b>       | 04/28/1998 |
| <b>Decision Date:</b> | 08/28/2014   | <b>UR Denial Date:</b>       | 05/13/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/09/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 61 year old female injured on 04/28/98 due to undisclosed mechanism of injury. The current diagnoses included pain in lower leg joint, unspecified hereditary/idiopathic peripheral neuropathy, degenerative lumbar/lumbosacral intervertebral disc disorder, lumbago, brachial neuritis or radiculitis, intervertebral cervical disc disorder with myelopathy of the cervical spine, and interstitial myositis. Clinical note dated 04/22/14 indicated the injured worker presented for complaints of chronic and severe neck pain and back pain rated 7/10. The injured worker reported pain was 10/10 without medications and 4/10 with medications. The injured worker reported medications allowed functional improvement, increased mobility, and tolerance of activities of daily living. Physical examination revealed deep tendon reflexes in upper extremities and lower extremities normal bilaterally, cervical spine tenderness to palpation paraspinal musculature with radiculopathy in the upper extremities bilaterally, bilateral cervical and bilateral lumbar spasm, decreased left upper extremity and right lower extremity strength, and mild tenderness in shoulders bilaterally. Medications included Norco 5-325mg twice a day, Restoril 15mg one to two tablets QHS, and Voltaren 1% gel apply 2g four times a day as needed. The initial request for Restoril 15mg #60 with one refill, Voltaren 1% gel and physical therapy (lumbar) frequency and duration not indicated was non-certified on 05/13/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Restoril 15mg #60 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use due to lack of proven efficacy with prolonged use and the risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic Benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. The injured worker has exceeded the 4 week treatment window. As such, the request for Restoril 15mg #60 with 1 refill is not medically necessary.

**Voltaren 1% gel:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (Diclofenac) Page(s): 112.

**Decision rationale:** Voltaren Gel (Diclofenac) is not recommended as a first-line treatment. Diclofenac is recommended for osteoarthritis after failure of oral non-steroidal anti-inflammatory drugs (NSAID's), contraindications to oral NSAIDs, for patients who cannot swallow solid oral dosage forms and after considering the increased risk profile with Diclofenac, including topical formulations. According to the Food and Drug Administration MedWatch, post-marketing surveillance of Diclofenac has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. With the lack of data to support superiority of Diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered. As such the request for Voltaren 1% gel is not medically necessary.

**Physical therapy (lumbar) frequency and duration not indicated:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of lumbar strain/sprain and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The request failed to specify the number of requested sessions to be provided. As such, the request for physical therapy (lumbar) frequency and duration unknown cannot be recommended as medically necessary at this time.