

<b>Case Number:</b>	CM15-0161940		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	10/07/1983
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 66-year-old female injured worker suffered an industrial injury on 10-7-1983. The diagnoses included lumbar spine strain-sprain, right thumb arthroplasty, bilateral wrist carpal tunnel syndrome, right shoulder rotator cuff tear and bilateral elbow epicondylitis. The treatment included aquatic therapy, surgery and psychotherapy. On 7-14-2015, the treating provider reported lumbar spine pain rated 7 out of 10 with bilateral lower extremity pain to the knees right greater than left. There was positive straight leg raise and decreased sensation. The pain was rated 4 to 5 with medications and 10 out of 10 without medications lasting 4 hours. The Fexmid was started 4-22-2015. Fioricet was ordered on 3-13-2015 for headache as needed. 6-10-2015 indicated the Temazepam was used for sleep. The injured worker had not returned to work. The requested treatments included Senna, Voltaren Gel, Fexmid, Neurontin, Temazepam, Fioricet, and MRI Lumbar Spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Senna #100:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic), opioid induced constipation treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) opioid induced constipation treatment.

**Decision rationale:** MTUS is silent. According to the OGD, opioid induced constipation treatment is recommended and that prophylactic treatment of constipation should be initiated. A discussion with the patient about increased activity, maintaining hydration and proper diet rich in fiber needs to occur as first line treatment. Also recommended is some laxatives may help to stimulate gastric motility and other over the counter medications that can loosen otherwise hard stools, add bulk and increase water content of the stool. The documentation provided did not include evidence of constipation or evaluation of the effectiveness of this medication as a prophylactic intervention. Senna is not medically necessary.

**Voltaren Gel 100gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines for topical analgesics, nonsteroidal anti-inflammatory drugs (NSAID) recommended Voltaren gel (Diclofenac) for relief of osteoarthritis pain in joints that lend themselves for treatment of the spine, hip or shoulder. The documentation provided did not indicate goals of treatment or include a specific pain assessment for this medication and evaluation. The physical site for application was not included in the medical record. There was no evidence of specific benefit or functional improvement. Therefore, Voltaren gel was not medically necessary.

**Fexmid 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril or Fexmid) is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more

effective than non-steroidal anti-inflammatory medications alone. In this case, the documentation provided did not include an acute condition or an acute exacerbation of a condition. This medication had been used for 3 months without evidence of benefit. Based on the currently available information, the medical necessity for this muscle relaxant has not been established. The requested treatment is not medically necessary.

**Neurontin 600mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin.

**Decision rationale:** Gabapentin (Neurontin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is no documentation of objective findings consistent with current neuropathic pain to necessitate the use of Gabapentin. In addition, there is no documentation of benefit from the previous use of Gabapentin. Medical necessity for Gabapentin has not been established. The requested medication is not medically necessary.

**Temazepam 15mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**Decision rationale:** Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is approved for the short-term treatment of insomnia. According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, and anticonvulsant and muscle relaxant. CA MTUS Guideline indicates "Functional improvement" is evidenced by a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment. The documentation provided indicated the medication was used for sleep beyond the maximum duration of 4 weeks without evidence of benefit. Therefore, Temazepam is not medically necessary.

**Promethazine 25mg #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Promethazine (Phenergan) (2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) anti-emetics for opioid nausea.

**Decision rationale:** MTUS is silent. Promethazine (Phenergan) is an anti-emetic. However, it is not recommended for nausea and vomiting secondary to chronic opioid use. Studies of opiate adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. In this case, there is no evidence of nausea and/or vomiting. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Fioricet #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Barbiturate-containing analgesics agent.

**Decision rationale:** According to the ODG, barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet contains butalbital, tylenol, and caffeine. The literature reported that butalbital containing combination analgesics should be avoided in migraine headache management. When used, it should be closely monitored to avoid overuse and dependence. It is recommended to be used less than 10 days/month. According to the CA MTUS, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Guidelines state that only one medication should be given at a time. Fioricet is commonly used for acute headaches, with some data to support it, but there are risks of medication overuse as well as rebound headaches. The documentation provided indicated the injured worker had headaches and had been using this medication chronically. In this case, there is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care with use of Fioricet. Guidelines do not recommend BCAs for chronic pain. Medical necessity for the requested treatment has not been established. The requested medication is not medically necessary.

**MRI Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004,  
Section(s): Special Studies.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines ACOEM Chapter 12, Low Back Complaints, Special Studies and diagnostic Treatment Considerations, Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatments and who would consider surgery an option. When the neurological exam is less clear, further physiological evidence of nerve dysfunction should be obtained before ordering an imaging study. If the physiological evidence indicated tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. Repeat magnetic resonance imaging are not routinely recommended and should be reserved for a significant change in symptoms or finding suggestive of significant pathology. The documentation provided did not indicate surgery was considered as an option and no evidence of a significant change. Therefore, lumbar magnetic resonance imaging was not medically necessary.