

<b>Case Number:</b>	CM14-0128643		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	08/15/2008
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 56 year old male who sustained an injury on 08/15/08. No specific mechanism of injury was noted. The injured worker has been followed for ongoing complaints of chronic low back pain. Prior treatment has included sacroiliac joint injections performed on 07/12/11. The injured worker was also utilizing medications with positive urine drug screen for Hydromorphone, Butalbital, and Lyrica. The injured worker was seen on 01/20/14 with continuing complaints of low back pain as well as more frequent headaches to the right side of the head. The injured worker also described pain in the jaw with grinding of his teeth at night. The injured worker described neck pain radiating to the right shoulder. Physical exam noted a normal gait. No specific neurological deficit was identified. Clinical note dated 07/07/14 indicated the injured worker complained of increasing low back pain radiating to bilateral lower extremities. The documentation indicated the injured worker reported noting a lessening of medication efficacy and worsening in quality of life. The initial request for Fioricet 5-325-40 mg # 60 and the 2 refills was non-certified on 07/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FIORICET 5-325-40MG # 60 AND THE 2 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**Decision rationale:** As noted on page 23 of the Chronic Pain Medical Treatment Guidelines, use of Fioricet, a barbiturate-containing analgesic, is not recommended for treatment of chronic pain. Research indicates the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy. Additionally, there is no indication in the documentation that establishes the benefits associated with the use of the medication. As such, Fioricet 5-325-40 mg # 60 and the 2 refills cannot be established as medically necessary at this time.