

<b>Case Number:</b>	CM14-0163326		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	10/23/2009
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Patient is a 33 year-old female with date of injury 10/23/2009. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/25/2014, lists subjective complaints as pain in the low back. Objective findings: Deep tendon reflexes were equal and symmetric in the bilateral lower extremities. There were no upper track findings. There was extremity edema noted on gross observation. Physician reported the rest of the examination remained unchanged, but did not reference any previous findings. Diagnosis: 1. Low back pain with L5-S1 5mm disc extrusion posteriorly to the left with an annular disc tear at L4-5, 2mm disc protrusion posteriorly to the right L3-4, 1 to 2 mm disc bulge posteriorly to the right. Disc desiccation noted at L1-2, L4-5 and L5-S1, per MRI from 03/14/2011 2. Lumbar radiculitis 3. Left knee pain secondary to straining injury 4. Left elbow strain-resolved. Patient underwent an EMG/NCV on 10/03/2012 in which no abnormalities were noted. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as 5 months. Medications:1. Biofreeze Gel, #2 SIG: as needed2. Robaxin 750mg, #120 SIG: twice daily3. Norco 10/325, #180 SIG: 6 a day4. Prilosec 20mg, #60 SIG: daily5. Xanax 0.5mg, #60 SIG: twice daily6. Phenergan 25mg, #50 SIG: daily as needed7. Percocet 5/325, #5 SIG: as needed8. Cymbalta 60mg, #30 SIG: daily.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request (DOS: 8/25/14) for Biofreeze gel as needed #2 tubes: Upheld**

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

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

**Decision rationale:** Biofreeze gel contains: Menthol USP 4-10%, Aloe, Arnica, Boswellia, Calendula, Green Tea, Ilex, Camphor, Lemon Balm. According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. There is no peer-reviewed literature to support the use of topical Biofreeze. Retrospective request (DOS: 8/25/14) for Biofreeze gel as needed #2 tubes is not medically necessary.

**Retrospective request (DOS: 8/25/14) for Robaxin 750mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**Decision rationale:** The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant Robaxin for at least 5 months, far longer than the short-term course recommended by the MTUS. Retrospective request (DOS: 8/25/14) for Robaxin 750mg #120 is not medically necessary.

**Retrospective request (DOS: 8/25/14) for Norco 10/325mg, 6 a day #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

**Decision rationale:** A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 5 months. Retrospective request (DOS: 8/25/14) for Norco 10/325mg, 6 a day #180 is not medically necessary.

**Retrospective request (DOS: 8/25/14) for Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Retrospective request (DOS: 8/25/14) for Prilosec 20mg #60 is not medically necessary.

**Retrospective request (DOS: 8/25/14) for Xanax 0.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter (Aprazolam, Xanax)

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

**Decision rationale:** The MTUS states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a 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. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The patient has been taking Xanax for much longer than the 4 weeks suggested by the MTUS. Retrospective request (DOS: 8/25/14) for Xanax 0.5mg #60 is not medically necessary.

**Phenergan 25mg daily as needed #50:** 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 Chapter

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

**Decision rationale:** The Official Disability Guidelines state that promethazine is not recommended for nausea and vomiting secondary to chronic opioid use. Phenergan 25mg daily as needed #50 is not medically necessary.

**Percocet 5/325mg as needed #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 Page(s): 60.

**Decision rationale:** According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. The patient is also taking Norco and there is no documentation of functional improvement. Percocet 5/325mg as needed #5 is not medically necessary.

**Cymbalta 60mg daily #30 with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 14,105.

**Decision rationale:** Recommended as an option in depressed patients for non-neuropathic pain, but effectiveness is limited. Patient appears to be a candidate for the use of Cymbalta, but the prescribing of 5 refills is excessive because the patient should be rechecked in regard to her condition before 6 months of medication has been used. Cymbalta 60mg daily #30 with 5 refills is not medically necessary.

**3-6 month authorization on all meds:** 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 Page(s): 8.

**Decision rationale:** The physician should periodically review the course of treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Authorizing refills for up to 6 months does not allow for periodic review is recommended in the MTUS. 3-6 month authorization on all meds is not medically necessary.