MAXIMUS Federal Services

Case Number:	CM13-0070359		
Date Assigned:	01/03/2014	Date of Injury:	08/22/2012
Decision Date:	04/28/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/24/2013

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 and Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in Oklahoma and 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 patient is a 45-year-old who reported an injury on August 22, 2012. The mechanism of injury information is not provided in the medical records. A review of the medical records reveals the patient's diagnosis is lumbar sprain, ICD9 code 847.2. The patient has received medication management, injection therapy, physical therapy, ambulatory aids such as a cane, and activity modification. The progress report dated November 4, 2013 reports the patient continued to have complaints of low back pain and bilateral leg pain. Objective findings upon examination revealed tenderness to palpation and decreased range of motion of the lumbar spine. There were noted spasms, and positive straight leg raise noted. Sensation was decreased to the lumbar spine as well.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 7.5 MG, 90 COUNT, DISPENSED ON NOVEMBER 4, 2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (FlexerilÂ®) Section Page(s): 41-42.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that the requested medication, cyclobenzaprine or Flexeril, is recommended as an option using a short course of therapy. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. The recommended length of time for use of this medication would be two to three weeks for symptom improvement in low back pain. The patient has been taking the requested medication at least since March of 2013, which exceeds the 2 to 3 week recommendation period, according to the Chronic Pain Medical Treatment Guidelines. As the patient continues to take the medication and has significant complaints of pain with its use, and it exceeds the recommended length of time that the Chronic Pain Medical Treatment Guidelines suggests for the use of cyclobenzaprine, the medical necessity for continued use cannot be determined. The request for Flexeril 7.5 mg, 90 count, dispensed on November 4, 2013, is not medically necessary or appropriate.

MENTHODERM GEL 120 MG, DISPENSED ON NOVEMBER 4, 2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113. Decision based on Non-MTUS Citation webside Drugs.com.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, it is stated that topical analgesics are largely experimental in use with few randomized control trials to determine the efficacy or safety of its use. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As there is no documentation in the medical record of any failed attempts at the use of antidepressants or anticonvulsants to treat the patient's condition, the medical necessity for continued use of the requested medication cannot be determined at this time. Topical analgesics are not considered a first-line treatment, and there is no documentation of any gastrointestinal injury with the use of oral medications, and no documentation of any failed attempts at the use of antidepressant or anticonvulsant medications to treat the patient's condition. The request for Menthoderm gel, 120 mg, dispensed on November 4, 2013, is not medically necessary or appropriate.