MAXIMUS Federal Services

Case Number:	CM14-0017242		
Date Assigned:	04/14/2014	Date of Injury:	01/08/2010
Decision Date:	08/08/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/11/2014

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 Physical Medicine and Rehabilitation 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:

The records presented for review indicate that this 51-year-old male was reportedly injured on January 8, 2010. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated February 11, 2014, indicated that the injured employee has improved overall since his revision fusion of L5-S1. Physical therapy has been completed, and the injured employee has transitioned to a home exercise program. The physical examination demonstrated decreased lumbar spine motion with flexion and extension. There was a normal lower extremity neurological examination, with the exception of diffuse decreased sensation in the right lower extremity. Diagnostic imaging studies reported evidence of healing of the interbody fusion at L5-S1 with pedicle screws in good position. A subsequent note dated April 9, 2014, stated the injured employee has reached maximum medical improvement. A request had been made for Cyclobenzaprine, Theraflex transdermal cream, and Keratek Gel and was not certified in the pre-authorization process on February 3, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R.9792.20 - 9792.26 (Effective July 18, 2009): Muscle relaxants (for pain) Page(s): 63-66 of 127.

Decision rationale: Cyclobenzaprine is a muscle relaxant indicated as a second line agent for short-term usage for episodic exacerbations of chronic low back pain. According to the most recent medical examinations on both February 11 and April 9, 2014, there were no complaints of low back pain exacerbations nor were there any muscle spasms present on examination. For these reasons, this request for Cyclobenzaprine 7.5mg #90 is not medically necessary.

1 PRESCRIPTION OF KERATEK GEL 4OZ: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 105 OF 127.

Decision rationale: Keratek gel is a compound of menthol and methyl salicylate. According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, lidocaine, or capsaicin. There was no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for Keratek gel 4oz is not medically necessary.

THERAFLEX TRANSDERMAL CREAM 20%/ 10%/ 4% 180GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R.9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 105 OF 127.

Decision rationale: Theraflex transdermal cream is a compounded topical agent containing methyl salicylate. According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, lidocaine, or capsaicin. There was no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for Theraflex transdermal cream 20%/ 10%/ 4% 180gm is not medically necessary.