

Case Number:	CM14-0128610		
Date Assigned:	08/18/2014	Date of Injury:	07/27/2012
Decision Date:	09/18/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 36 year old male who reported injury on 07/27/2012 due to lifting a tray. The injured worker has a diagnosis of lumbago, lumbar radiculopathy, low back pain with multilevel degenerative disc disease, facet arthropathy, and stenosis. Past treatment included physical therapy, as well as medications. Specifically, he was noted to have tried gabapentin, Relafen, Ultram, ibuprofen, and Aleve, in the past without any benefit. Diagnostic testing included an MRI on 04/15/2013 which was noted to reveal degenerative disc changes at multiple levels, an x-ray of the lumbar spine on 03/05/2013 which described spina bifida at L5, mild narrowing of multiple discs, and some narrowing of the lumbar canal on a congenital basis. Surgical history was not documented. On 07/17/2014, the injured worker complained of low back pain rated about an 8/10 to 9/10, and described his pain as constant, sharp and "piercing". The injured worker also reported difficulty standing on his left leg, pain radiating and shooting down the back of the right leg. Physical examination findings included tenderness to palpation in the left greater than right paralumbar muscles, lumbar spine flexion was limited at 20 to 30 degrees with end points of pain. Lumbar spine extension was at 5 degrees with endpoints of pain. The injured worker deferred lateral flexion secondary to discomfort. Straight leg raise testing was positive on the left, negative on the right. Current medications were not listed on the most recent clinical note. The treatment plan was for Retrospective request for Flexeril 10 mg quantity: 30.00 (date of service 7/17/2014), Retrospective request for Biofreeze gel quantity: 2 (date of service 7/17/14). The rationale for the request was not provided. The request for authorization form was provided on 07/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Flexeril 10mg QTY: 30.00 (DOS 7/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant (for pain)Cyclobenzaprine (Flexeril) Page(s): 63, 64.

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

Decision rationale: The request for Retrospective request for Flexeril10 mg QTY: 30.00 (DOS 7/17/2014,) is not medically necessary. The injured worker reports continuing of low back pain for 2 years after injury. California Medical Treatment Utilization Schedule (MTUS) Guidelines state that Flexeril is a muscle relaxer recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Additionally, the request did not provide a frequency. As such, the request for is not medically necessary.

Retrospective request for Biofreeze gel QTY: 2 (DOS 7/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

Decision rationale: The request for retrospective request for Biofreeze gel QTY:2 (DOS 7/17/14) is not medically necessary. The Official Disability Guidelines may recommend Biofreeze as an optional form of cryotherapy for acute pain as a randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. The injured worker reported persistent low back pain for 2 years after injury, representing chronic, not acute, pain. As the guidelines only recommend use of Biofreeze for acute pain and the injured worker is being treated for a chronic pain condition, the request is not supported. As such, the request is not medically necessary.