MAXIMUS Federal Services

Case Number:	CM14-0025919		
Date Assigned:	06/04/2014	Date of Injury:	01/07/2005
Decision Date:	07/11/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	03/01/2014

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 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 45-year-old with a reported injury date on January 7, 2005; the mechanism of injury was not provided. The injured worker's diagnoses include chronic pain, cervical radiculitis, and status post cervical spinal fusion. The pain medicine re-evaluation dated May 1, 2014 noted that the patient had neck pain that radiates down the bilateral upper extremities low back pain that radiates down the lower left extremity, and upper extremity pain in the left fingers and hand. It was also noted that pain was rated 3/10 with medication, 8/10 without. Additionally, it was noted that the patient's pain was reported to be worse since her last examination. Examination of the cervical spine noted tenderness between C5-7, tenderness in the left paravertebral musculature along C4-7, and myofascial trigger points were noted in the left trapezius muscle. It was also noted that the range of motion on the cervical spine was slightly to moderately limited. Examination on the lumbar spine noted tenderness in the spinal vertebral area between L3-S1. Examination of upper extremities noted tenderness to the left acromioclavicular joint and the left anterior shoulder. The range of motion of the left shoulder was decreased due to pain. Additionally, it was noted that the motor exam showed decreased strength of extensor muscles of the flexor muscles in the left upper extremity. The treatment plan included a refill of Enovarx-ibuprofen 10%. The Request for Authorization Form was not provided within the available documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF ENOVARX- IBUPROFEN 10%, QUANTITY OF ONE: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical nonsteroidal anti-inflammatory drugs may be recommended for osteoarthritis and tendonitis in particular, that of the knee and elbow. The guidelines also state that it is recommended for short term use between four to twelve weeks. There is little evidence to utilize topical NSAIDs (non-steroidal anti-inflammatory drugs) for treatment of osteoarthritis of the spine, hip, or shoulder. There was a lack of objective clinical findings within the available documentation that the injured worker would benefit from the use of this medication; the injured worker had documented symptomatology of the spine. Additionally, it remains unclear how long this requested medication has currently been prescribed, as it is recommended to be used only up to twelve weeks. Furthermore, there is a lack of rationale provided within the available documentation as to why this requested medication is being prescribed. Moreover, there was a lack of documentation provided that this requested medication has provided the desired therapeutic effect. The request for one prescription of Enovarx-Ibuprofen 10%, quantity of one, is not medically necessary or appropriate.