

Case Number:	CM14-0036785		
Date Assigned:	06/25/2014	Date of Injury:	06/19/2004
Decision Date:	07/25/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/26/2014

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 Internal 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:

The injured worker is a 56 year old female who is reported to have sustained work related injuries on 06/19/04. Records indicate that the injured worker has chronically been treated for neck, low back, and right lower extremity pain. The injured worker has been identified as having a right S1 radiculopathy. Medications have included Tylenol #4 with Codeine, Skelaxin 800mg, and Biofreeze gel. The injured worker routinely sees a provider who gives chiropractic adjustments and provides prescriptions of oral medications. The serial records do not indicate that the injured worker achieves any substantive relief with these medications. At her periodic evaluations, her pain levels were grossly elevated despite chronically being on these medications. The record contains an Agreed Medical Evaluation (AME) report dated 02/13/14 in which the AME suggests that the use of opiates and muscle relaxers should be limited to periodic exacerbations. The record does not include any urine drug screens. The record contains a utilization review determination dated 02/25/14 in which requests for Biofreeze gel 4oz. tube, Skelaxin 800mg #90, and Tylenol #4 with Codeine #120 were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 prescription of Biofreeze Gel 4oz. tube #1 between 2/11/2014 and 2/11/2014: 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 Topical Analgesics Page(s): 112-113.

Decision rationale: The request for Biofreeze gel 4 oz. tube #1 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has chronic cervical and lumbar pain associated with her workplace injury. The injured worker has further been identified as having a right S1 radiculopathy. The records provide no data which indicates that the injured worker receives benefit from this topical analgesic. It would further be noted that Chronic Pain Medical Treatment Guidelines does not support the use of topical analgesics noting that the efficacy of these medications has not been established through rigorous clinical trials. As such, medical necessity has not been established.

Prospective request for 1 prescription of Skelaxin 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Skelaxin (metaxalone).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The request for Skelaxin 800mg #90 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has chronic cervical and lumbar myofascial pain. The injured worker has subjective reports of muscle spasms not documented consistently on physical examinations. It would be noted that despite taking this medication for over a year, the injured worker continues to have subjective complaints of myospasms despite routinely taking this medication. As such, the efficacy of the continued use of this medication is not established.

Prospective request for 1 prescription of Tylenol #4 with Codeine #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request for Tylenol #4 with Codeine #120 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a chronic history of cervical and lumbar myofascial pain and is noted to have a right S1 radiculopathy. Subjective reports at follow up visits do not suggest that the injured worker receives any benefit from this medication. There are no serial visual analog scale scores or other measures of functional improvements on this medication. Additionally, given the chronicity of the use, there is no evidence of a chronic pain management contract or serial urine drug screen to establish compliance. As such, the medical necessity for continued use would not be supported under Chronic Pain Medical Treatment Guidelines.

