

Case Number:	CM14-0092958		
Date Assigned:	09/12/2014	Date of Injury:	09/20/2010
Decision Date:	10/31/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/19/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 35-year-old male with a reported injury on 09/20/2010. The mechanism of injury was pulling and pushing repetitively. The injured worker's diagnoses included right shoulder pain and anxiety disorder. The injured worker's previous treatments included physical therapy, a sling, and medications. The injured worker's diagnostic testing was not provided. The injured worker's surgical history included a right shoulder arthroscopic acromioplasty, repair of superolateral tear from anterior to posterior, Mumford, and debridement. On 04/16/2014, the injured worker had an arthroscopic repair of the right superolateral tear from anterior to posterior and debridement. The injured worker was evaluated postoperatively on 04/30/2014. He complained of pain to his right shoulder surgery rated 9/10 in severity. He was participating in physical therapy. The clinician observed and reported that the injured worker was wearing his sling. A bandage was in place over the right shoulder with no strike through bleeding. The rest of the examination was unchanged. The injured worker was evaluated on 01/07/2014 where the clinician reported tenderness on the anterior and lateral of the right shoulder on palpatory examination. The injured worker's medications included Norco 10/325 mg, Ambien, Robaxin, Cymbalta, and Biofreeze topical roll on gel. These medications are unchanged from 12/12/2013. The requests were for Robaxin 750 mg #120 and Biofreeze topical roll on gel. No rationale for the request was provided. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Robaxin 750mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: The request for Robaxin 750mg #120 is not medically necessary. The injured worker continued to complain of right shoulder pain. The California MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Methocarbamol falls under the category of antispasmodics which are used to decrease muscle spasm and conditions such as low back pain although these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The injured worker did not have any documented back pain or muscle spasms either subjectively or objectively. The injured worker has been prescribed Robaxin from at least 12/12/2013 through 04/30/2014 which exceeds the short term recommendation for use. Additionally, the request did not include a frequency of dosing. Therefore, the request for Robaxin 750 mg #120 is not medically necessary.

Biofreeze topical roll-on gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics - Biofreeze topical roll-on gel Page(s): 112-11.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Biofreeze® cryotherapy gel

Decision rationale: The request for Biofreeze topical roll-on gel is not medically necessary. The injured worker continued to complain of right shoulder pain. The Official Disability Guidelines recommend Biofreeze cryotherapy gel as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. No documentation was provided indicating any benefit from using the Biofreeze which the injured worker had been using since 12/12/2013. Additionally, the request did not include a frequency of use or a site of application. Therefore, the request for Biofreeze topical roll-on gel is not medically necessary.