

Case Number:	CM14-0186673		
Date Assigned:	11/14/2014	Date of Injury:	08/31/2011
Decision Date:	01/05/2015	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	11/10/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 has sustained a work-related injury on May 31 2011. Subsequently, the patient developed a chronic back pain. According to a progress report dated on October 22 2014, the patient was complaining of back with a severity rated 5/10. The patient physical examination demonstrated lumbar spine with reduced range of motion, negative leg lift and normal neurologic examination. The patient was diagnosed with chronic low back pain. The provider requested authorization for the following medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil 10mg, W/ 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 13.

Decision rationale: According to MTUS guidelines, Tricyclics (Amitriptyline is a tricyclic antidepressant) are generally considered as a first a first line agent for pain management unless they are ineffective, poorly tolerated or contraindicated. Elavil could be used to be used to treat insomnia related to pain, however the provider prescribed Elavil. There is no clear justification

of the prescription of Elavil in the patient file. The patient developed chronic pain syndrome that did not respond to current pain medications and Elavil could be used. However a 3 months' supply of Elavil could not be approved without periodic documentation efficacy and safety. Therefore, the prescription Elavil 10mg, W/ 3 Refills is not medically necessary.

Neurontin 300mg, W/ 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 19.

Decision rationale: According to MTUS, Neurontin has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered to be first line treatment for neuropathic pain. However there is a limited research to support its use of back or neck pain. There is no documentation of the efficacy of previous use of Neurontin. Based on the above, the prescription of Neurontin 300mg, W/ 3 Refills is not medically necessary.

Biofreeze Gel, All W/ 3 Refills: Upheld

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

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. According to ODG guidelines, <Biofreeze is recommended 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. This 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 (http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm). There was no recent documentation of failure or intolerance of oral first line drugs for pain management. Therefore, the prescription of Biofreeze Gel, All W/ 3 Refills is not medically necessary.