

Case Number:	CM14-0071307		
Date Assigned:	07/14/2014	Date of Injury:	09/29/2007
Decision Date:	03/05/2015	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58 year-old female with an original date of injury on September 29, 2007. The industrially related diagnoses are cervical radiculopathy, lumbar disc degeneration, left shoulder pain, osteoarthritis, anxiety, opioid dependence, constipation, and history of suicidal ideation. The patient has had a suprascapular nerve block on January 27, 2014 with 50 to 80% overall improvement over a duration of three weeks. An MRI of the right shoulder on April 2, 2012 showed myeloproliferative changes in the acromioclavicular joint, status post acromioplasty and rotator cuff repair, and subtle bone bruise seen at the superior and outer portion of the humeral head. A MRI of the left shoulder on April 21, 2012 showed moderate proliferative changes in the acromioclavicular joint with impingement of the supraspinatus muscle tendon and tendon insertion into the humeral head, and mild effusion seen in the glenohumeral joint with extension to subdeltoid bursa consistent with bursitis. The patient was receiving treatment with anti-seizure medication, NSAIDs, opioid pain medications, topical analgesic medication, aquatic therapy, and home exercises. An EMG and nerve conduction study of the bilateral upper extremity on May 21, 2012 was within normal limits, and polyneuropathy secondary to generalized systemic neuropathic process was noted. The disputed issues are the requests for Biofreeze 4% gel three times daily quantity 1, Ketoprofen 50 mg capsule when every 12 hours quantity 60, and Lyrica 75 mg one capsule at bedtime quantity 30. A utilization on April 24, 2014 is noncertified these requests. With regards to Biofreeze, there was no clear detail provided as to why the Biofreeze is required is supposed to the patient using at home local application of cold packs or using an over-the-counter topical agent. Therefore,

this medication request was denied. With regards to ketoprofen, the stated rationale was there was no clear detail provided as to what specific overall functional benefit has been achieved with the use of Ketoprofen as opposed to using an over-the-counter anti-inflammatory. As such, this request was denied. With regards to Lyrica, the utilization review stated there was no indication on physical exam of an objective neuropathic pain component occurring from the diabetic neuropathy for postherpetic neuralgia to support the need for Lyrica. Furthermore, this medication has limited literature evidence in addressing radiculopathy symptoms. Lastly, there is no detail provided as to why this prescription medication is being requested, as there was no documentation of patient activity of daily living limitations, and no significant overall functional improvement has been achieved with this medication. Therefore, the request for Lyrica was noncertified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze 4% gel #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation ODG Low Back, Biofreeze Cryotherapy Gel

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Biofreeze

Decision rationale: There are no provisions for topical Biofreeze in the California Medical Treatment Utilization Schedule. Therefore, the Official Disability Guidelines are referenced, which support the use of Biofreeze only in the context of acute low back pain. Specifically, the Official Disability Guidelines Low Back Chapter under the Biofreeze and Cryotherapy section state: "Recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. 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." The prescriber did not document the purpose of biofreeze is for the treatment of acute lower back pain, as guidelines suggests. herefore, this request is not medically necessary.

Ketoprofen 50mg capsule #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 71-72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID section Page(s): 71-72.

Decision rationale: Regarding the request for Ketoprofen, the Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Ketoprofen is providing any specific analgesic benefits or any objective functional improvement. A progress note on 1/28/2014 indicated the patient has 10/10 with medication and 10/10 pain without medication. Furthermore, the patient was also prescribed topical Voltaren and ibuprofen gel concurrently with Ketoprofen without clear explanation of why these agents are needed at the same time. Therefore, the currently requested Ketoprofen is not medically necessary.

Lyrica 75mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 19-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica in the Anti-epileptic drugs Section Page(s): 19-20.

Decision rationale: Regarding request for pregabalin (Lyrica), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. Within the documentation available for review, a progress note on 4/3/2014 indicated the patient has had ongoing treatment with Lyrica since 11/5/2013. However, there is no identification of any specific analgesic benefit and no documentation of specific objective functional improvement. In fact, a progress note on 1/28/2014 indicated the patient continue to have 10/10 pain despite the usage of Lyrica. In the absence of such documentation, the currently requested pregabalin (Lyrica) is not medically necessary.