

Case Number:	CM15-0143047		
Date Assigned:	08/03/2015	Date of Injury:	09/26/2014
Decision Date:	09/28/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/23/2015

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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 43 year old male who sustained a work related injury September 26, 2014 after falling down 8 steps. He struck his head and neck on a concrete floor without loss of consciousness. Past history included hypertension and rotator cuff repair 2006. Impression was documented as head injury, lumbosacral strain. He was treated with medication and underwent a CT of the brain and cervical spine, which were negative. An x-ray of the lumbar spine revealed a possible L2 compression fracture 20% with no retropulsion. According to a neurological consultation, performed April 16, 2015, the injured worker presented with complaints of recurrent occipital head pain radiating to the top of the head, rated 4 out of 7. The pain is described as pressure like with photophobia and phonophobia. Impression is documented as status post closed head injury without loss of consciousness; suboccipital neuralgia; musculoligamentous strain involving the cervical paraspinal areas. Treatment plan included recommendation for a series of nerve blocks and a course of co-adjuvant medication. At issue, is the request for authorization for Biofreeze and Motrin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800mg #60 refill 1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications; NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medication Page(s): 22.

Decision rationale: The patient presents with head pain radiating to the top of the head. The current request is for Motrin 800 mg #60 refill 1. The treatment report dated 04/16/2015 (16B) states, The patient reports recurrent, daily sub occipital head pain radiating to the top of the head, on and off for an unspecified period of time Closing his eyes and taking medications improves it. The patient's current list of medications include: Metoprolol and Norco. The report making the request was not made available for review. The MTUS Guidelines page 22 on anti-inflammatory medication states that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. In this case, the MTUS Guidelines support the use of anti-inflammatories as first-line treatment to reduce pain and improve function. The current request is medically necessary.

Biofreeze (unspecified dosage and quantity) refill 1: Upheld

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

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.

Decision rationale: The patient presents with head pain radiating to the top of the head. The current request is for Biofreeze (unspecified dosage and quantity) refill 1. The treatment report dated 04/16/2015 does not discuss the rationale for this request. None of reports document a history of use with this medication. The MTUS guidelines do not address Biofreeze gel. The ODG guidelines under the Low Back chapter on Biofreeze states, 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. In this case, the patient does not present with acute low back pain. The 04/16/2015 report documents cervical spine tenderness with no discussion of back pain. Therefore, the patient does not meet the ODG Guidelines for the use of Biofreeze. The current request is not medically necessary.