MAXIMUS Federal Services

Case Number:	CM15-0028835		
Date Assigned:	02/20/2015	Date of Injury:	07/18/2013
Decision Date:	04/02/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/17/2015

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: New Jersey, New York
Certification(s)/Specialty: Family Practice

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 male, who sustained an industrial injury on 7/18/13. He has reported neck and back pain. The diagnoses have included neck pain, thoracic pain and low back pain. Treatment to date has included physical therapy, activity restrictions and medication. (MRI) magnetic resonance imaging of cervical spine revealed mild bilateral foraminal stenosis at C5-6 with broad based bulge and posterior disc protrusion at C5 and C6. (CT) computerized tomography scan of lumbar spine showed age indeterminate compression fracture of T12 with 75% loss of height and a healing fracture of left posterior 12th rib. Currently, the injured worker complains of ongoing neck, lumbar and thoracic spine pain. Progress report dated 1/19/15 noted he is doing well with medication regimen and it allows him to continue to be more functional; he is also having difficulty sleeping. On 2/6/15 Utilization Review non-certified Elavil 10mg #30, with 1 refill, noting guidelines do not support use of tricyclic antidepressant due to a lack of EKG screening and Maxfreeze gel 2 tubes, noting the lack of documented evidence of significant benefit from this medication. The MTUS, ACOEM and non-MTUS Guidelines, were cited. On 2/11/15, the injured worker submitted an application for IMR for review of Elavil 10mg #30 with 1 refill and Maxfreeze gel 2 tubes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil 10mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 25.

Decision rationale: The request is considered not medically necessary. Although Elavil is beneficial in patients with neuropathic pain and insomnia, it is contraindicated in patients with cardiac conduction dysfunction and can cause heart block and arrhythmias. Patients who are older than 40 should have a screening EKG. This 58 year-old patient does not have an EKG on file. Therefore, the request is considered not medically necessary at this point.

Maxfreeze Gel, 2 tubes: 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): 111.

Decision rationale: The request is medically unnecessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when antidepressants and anticonvulsants have failed. There are no guidelines for the use of menthol with the patient's spine complaints. There were no documented goals of treatment or evidence of improved function with use of Max-freeze. Therefore, the request is considered not medically necessary.