MAXIMUS Federal Services

Case Number:	CM15-0048047		
Date Assigned:	03/20/2015	Date of Injury:	04/08/2003
Decision Date:	04/24/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/13/2015

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: Connecticut, California, Virginia
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 62 year old, female patient, who sustained an industrial injury on 04/08/2003. A primary treating office visit dated 01/06/2015, reported subjective complaints of ongoing neck pain with radicular symptom down bilateral arms. She is now having difficulty grasping and gripping objects. The patient reported for the past month she has experienced increased numbness, tingling and weakness in the left upper extremity that especially is affecting the hand, and 4th and 5th digits of that hand. She is currently prescribed Tylenol #3, Biofreeze, and Valium. Objective findings showed she had increased tenderness to cervical paraspinal muscle, more so on the left extending into the left trapezius. She has almost full range of motion of the neck without too much discomfort. She is with obvious atrophy and inability to extend the third through fifth digits on the upper right extremity. She is able to flex and extend all the digits on her left hand. The following diagnoses are applied: persistent low back pain, bilateral lower extremity pain. L4-5 left sided protrusion per MRI 2004. Status post cervical revision fusion, C5-6 12/2013. Chronic left shoulder pain. Nerve conduction study performed on 05/12/2014 showed right C8 radiculopathy, and a history of hepatitis C. She is given a one-month's supply of medications, recommending a magnetic resonance imaging of cervical spine, spine consultation and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Valium 5mg Qty:60 (DOS 01/16/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Weaning medications Page(s): 24,127.

Decision rationale: The patient has persistent low back pain. The notes offer no objective exam regarding the back that indicates any level of spasm, etc. that may warrant considering treatment with benzodiazepines. The records do indicate that the patient rarely requires the medications, and uses them for acute flare episodes. The MTUS does not recommend benzodiazepines for long-term use in cases of chronic pain because long-term efficacy is unproven and there is a risk of dependence. The range of action of this class of drug includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. None of these indications are clearly indicated in the provided notes. As tolerance to the muscle relaxing effects of benzodiazepines occurs within weeks, it is likely that this patient should be weaned from the medication, making the modification by utilization review recommending a taper medically appropriate; if the patient requires the medications as rarely as indicated by the recent notes, the quantity (48) should still meet the clinical need. Therefore, given the provided records and the current medical evidence, the initial request to continue use of Valium in this patient is not medically necessary.

Retrospective Biofreeze roll Qty: 2 rolls (DOS 01/16/15): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapterBiofreeze gel.

Decision rationale: Biofreeze is a compound containing the active ingredient menthol. The MTUS states there is little to no research to support the use of many compounded agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Menthol is not considered a non-recommended agent per the MTUS. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. While these agents are supported by little to no research, and are only recommended for consideration in cases of neuropathic pain when medications have failed, the recent note provided does indicate that the patient benefits from the treatment, and this benefit is supported by the ODG, which provides more specific guidance on Biofreeze. Given the recommendation for use in low back pain in the Official Disability Guidelines as a more specific mechanism of assessment than the general topical analgesic guidance from the MTUS and the provided records, the request for Biofreeze is considered medically necessary.