

Case Number:	CM13-0041814		
Date Assigned:	12/20/2013	Date of Injury:	01/05/2004
Decision Date:	02/19/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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 patient is a 46 year old female who reported an injury on 01/05/2004. Previous treatments included cervical fusion, physical therapy, acupuncture, and medication management. The patient's medications were monitored and the patient was assessed for aberrant behavior with the use of urine drug screens. The patient's medications included Amrix extended release 15 mg, Lidoderm patches, Biofreeze gel, and Norco 10/325 mg. The patient's most recent clinical evaluation included tenderness and spasming to palpation along the paraspinal cervical musculature with complaints of increased neck pain and stiffness. The patient's diagnoses included status post C4-6 anterior cervical discectomy and fusion, complex regional pain syndrome over the right upper extremity, lumbar disc degeneration, intermittent low back pain, and cervical radiculopathy. The patient's treatment plan included trigger point injections, and continuation of medications with the addition of Norco 10/325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The clinical documentation submitted for review does provide evidence that this patient was prescribed this medication for breakthrough pain. California Medical Treatment Utilization Schedule does not recommend opioids as a first-line medication for pain. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first-line treatments to include antidepressants and anticonvulsants. As such, the requested Norco 10/325 mg #90 is not medically necessary or appropriate.

Amrix ER 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants for long durations of time. Therefore, continued use of this medication would not be supported. Additionally, the patient has tenderness and spasming along the paraspinal cervical musculature. Therefore, the efficacy of this medication cannot be determined. As such, the requested Amrix extended release 15 mg #30 is not medically necessary or appropriate.

Biofreeze Gel 4%: Upheld

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

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

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as a first-line treatment. The clinical documentation submitted for review does provide evidence that the patient is also using Lidoderm patches. The clinical documentation submitted for review does not provide any evidence that the patient requires 2 topical analgesics. Additionally, Official Disability Guidelines recommend this medication for acute pain as an alternative to cold pack applications. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to self-managed cold pack applications. As such, the requested Biofreeze gel 4% is not medically necessary or appropriate.