

Case Number:	CM14-0116023		
Date Assigned:	08/04/2014	Date of Injury:	04/08/2003
Decision Date:	09/26/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/24/2014

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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in California. 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/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 injured worker is a 62 year old female who reported an injury on 04/08/2008 due to an unknown injury. Diagnoses were persistent low back pain/bilateral lower extremity pain; L4-5 left-sided protrusion per MRI of 2004; status post cervical revision fusion, C5-6, on 12/2013; prior surgery in May and June. MRI revealed myelomalacia at C5-6. Chronic left shoulder pain. The EMG (Electromyography) was a negative study of the right upper extremity. There was sensory median neuropathy across the right wrist on EMG (Electromyography) study in 01/2007. The injured worker had history of hepatitis C, evaluated by gastroenterologist periodically. Liver biopsy was done in 2006. Past treatments were not reported. Surgical history was a cervical fusion of the C5-6. Physical examination on 05/15/2014 revealed complaints of the upper extremities. It was reported that the injured worker had progressive atrophy and numbness and tingling in the right upper extremity. She had a claw hand deformity. Examination revealed the injured worker had atrophy of the intrinsic hand muscle. She had ulnar claw deformity in the right hand. Medications were Tylenol No. 4, Biofreeze roll-on, and Valium 5 mg. Treatment plan was to continue medications as directed. The rationale was not submitted for review. The request was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol 4 # 120 dispensed on 5/15/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, Pure-Agonist, Ongoing Management, Codeine Page(s): 74, 78, 92.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that Tylenol with codeine should be used for moderate to severe pain and there should be documentation of the "4 A's" for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug-taking behavior. There was no documentation of the "4 A's" for ongoing monitoring. The efficacy of the medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request of Tylenol 4 # 120 dispensed on 5/15/14 is not medically necessary and appropriate.

Biofreeze Roll-on #1 dispensed on 5/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. Decision based on Non-MTUS Citation www.biofreeze.com.

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 Cryotherapy Gel.

Decision rationale: The Official Disability Guidelines state that Biofreeze cryotherapy gel is recommended as an optional form of cryotherapy for acute pain. Biofreeze is a non-prescription 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 is 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. This medication can be purchased over-the-counter. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, this request Biofreeze Roll-on #1 dispensed on 5/15/14 is not medically necessary and appropriate.

Valium 5mg #60 dispensed on 5/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not recommend benzodiazepines for long-term use and most guidelines limit use to 4 weeks. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. There was evidence that the injured worker had been on this medication longer

than recommended. Therefore, Valium 5mg #60 dispensed on 5/15/14 is not medically necessary and appropriate.