

Case Number:	CM15-0015741		
Date Assigned:	02/03/2015	Date of Injury:	10/05/2011
Decision Date:	03/23/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/27/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 female patient, who sustained an industrial injury on 10/05/2011. A primary treating office visit dated 01/10/2015 reported subjective complaint of significant pain in her right neck and down into her arm associated with tingling in her left 3 ulnar fingers intermittently. She is noted using a transcutaneous nerve stimulator unit along with a heating pad after her workday which offers some relief of discomfort. In addition, she is noted performing exercise at home, using a foam roller; although, recent new training caused a flare up of symptom. She reported new onset of significant right neck pain, elbow, forearm, radial hand, right face pains and headache. The following medications are prescribed; Methocarbamol 500MG, and Biofreeze with note she avoids the use of Advil secondary to gastrointestinal upset. She is diagnosed with myalgia, myositis unspecified; spasm of muscle; pain in limb; degeneration of cervical intervertebral disc; and spinal stenosis of cervical region. A request noted made on 01/12/2015 for Acupuncture session and Biofreeze Gel. On 01/16/2015 Utilization Review non-certified the request, noting the CA MTUS, ACOEM Guidelines, Chronic Pain, Acupuncture Treatment Guidelines were cited. The injured worker submitted an application on 01/27/2015 for independent medical review of services requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture times eight visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on MTUS Citation 9792.20. Medical Treatment Utilization Schedule Definitions - (f) (functional improvement)

Decision rationale: Acupuncture times eight visits is not medically necessary per the MTUS Acupuncture Medical Treatment Guidelines. The guidelines states that the time to produce functional improvement is 3 to 6 treatments. The frequency is 1 to 3 times per week with the optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20. The documentation indicates that the patient already had 26 total acupuncture sessions. The documentation does not indicate evidence of functional improvement therefore the request for eight more visits is not medically necessary.

Meds times 1 Biofreeze 0.2-3.5% gel three bottles times six refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Meds times 1 Biofreeze 0.2-3.5% gel three bottles times six refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates on a medical review of progress notes that the patient has used Biofreeze in April, June, and July of 2013. The MTUS states that these topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation does not indicate failure of antidepressants or anticonvulsants. There is no evidence of functional improvement with prior Biofreeze use. There is no intolerance of oral medications. The request for Biofreeze 0.2-3.5% gel three bottles times six refills is not medically necessary.