

Case Number:	CM14-0140208		
Date Assigned:	09/08/2014	Date of Injury:	04/15/2009
Decision Date:	10/21/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	08/29/2014

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 Internal 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 55 year old female who sustained an injury on 04/15/09 while lifting a garbage bad with a sudden onset of pain. The injured worker was followed for persistent neck and left shoulder pain. The injured worker has had multiple surgical repairs of the left shoulder with ongoing complaints of pain. The injured worker was seen on 08/01/14 for persistent neck and left shoulder pain. The injured worker did report some relief with medications, primarily Motrin and topical Biofreeze. The injured worker was also utilizing Omeprazole. No specific findings were reported on this date of service. No significant changes were indicated. The injured worker was prescribed Zanaflex at this evaluation for myofascial pain in the cervical region as well as for sleep. No previous neurological findings were noted. No prior imaging was provided. The requested medications and testing were denied on 08/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to the use of Zanaflex 4mg quantity 60, this reviewer would have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The use of Zanaflex on a trial basis to address myofascial pain in the cervical region would be appropriate given that the injured worker's complaints were noted to be increasing by August of 2014. This medication was not requested for an extended period of time which is consistent with current evidence based guideline recommendations. As such, this reviewer would have recommended this medication as medically appropriate.

Motrin 800mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: In regards to the use of Motrin 800mg quantity 90, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of prescription NSAIDs is not recommended by current evidence based guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flareups of chronic pain. There is no indication that the use of NSAIDs in this case was for recent exacerbations of the injured worker's known chronic pain. As such, the injured worker could have reasonably transitioned to an over-the-counter medication for pain.

Biofreeze Gel 2 Tubes: Upheld

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

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

Decision rationale: In regards to the use of Biofreeze, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The primary component of Biofreeze is menthol. This topical analgesic is readily available over-the-counter and does not require a prescription for use. As such, there would be no indication for a prescription of this medication.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, proton pump inhibitors

Decision rationale: In regards to the use of Prilosec 20 mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary.

NCV Left Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The clinical documentation provided for review did not identify any specific objective findings to support possible peripheral neuropathic conditions that would require confirmation by NCS in the left upper extremity. This test can be considered appropriate per guidelines in cases where a particular neurological diagnosis may be in question; however, given the insufficient objective findings on physical exam, this reviewer would not have recommended this medication as medically necessary.