

Case Number:	CM13-0031574		
Date Assigned:	12/04/2013	Date of Injury:	05/26/2011
Decision Date:	02/26/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	10/03/2013

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 48-year-old male who reported an injury on 05/26/2011 due to cumulative trauma while performing normal job duties. The prior treatments included injection therapy, shockwave therapy, surgical intervention, physical therapy, and medications. The patient reportedly sustained injury to multiple body parts to include the bilateral shoulders, bilateral hands, bilateral wrists, bilateral knees, and lumbar spine. The patient's most recent clinical examination findings from 05/2013 included persistent pain complaints of the lumbar spine rated at a 7/10 to 8/10. The physical findings included tenderness to palpation with evidence of spasming of the cervical spine with a positive foraminal compression test and positive Spurling's test. The examination of the bilateral shoulders did not reveal any abnormal findings. The examination of the elbows revealed tenderness to the lateral epicondylar areas. The evaluation of the wrist and hand revealed tenderness to palpation of the bilateral wrist joints with an abnormal 2-point discrimination test greater than 8 mm and a positive Phalen's test bilaterally for carpal tunnel medial epicondylitis. The evaluation of the lumbar spine revealed decreased sensation in the L4, L5, and S1 dermatomes bilaterally with decreased range of motion secondary to pain and tenderness upon palpation to the paraspinous musculature. The patient's diagnoses included lumbar disc herniation, coccydynia, anxiety and depression, medication related gastritis, and insomnia. The patient's treatment plan included continuation of medications and activity modifications

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Section Page(s): 60.

Decision rationale: The requested Ketoprofen is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends the continued use of medications for a patient's chronic pain be supported by documentation of a quantitative pain relief assessment and evidence of functional benefit. The clinical documentation submitted for review does not provide any evidence of functional benefit or pain relief resulting from medication usage. Additionally, the request as it is written does not clearly identify the formulation, duration, or frequency of the requested medication. Therefore, medical necessity cannot clearly be established. As such, the requested Ketoprofen is not medically necessary or appropriate.

Flurbiprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Section Page(s): 60.

Decision rationale: The requested Flurbiprofen is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends the continued use of medications for a patient's chronic pain be supported by documentation of a quantitative pain relief assessment and evidence of functional benefit. The clinical documentation submitted for review does not provide any evidence of functional benefit or pain relief resulting from medication usage. Additionally, the request as it is written does not clearly identify the formulation, duration, or frequency of the requested medication. Therefore, medical necessity cannot clearly be established. As such, the requested Flurbiprofen is not medically necessary or appropriate.