

Case Number:	CM13-0038682		
Date Assigned:	12/18/2013	Date of Injury:	10/26/2011
Decision Date:	03/25/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/01/2013

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, has a subspecialty in Pain Management, and is licensed to practice in Georgia. 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 claimant presents with neck, low back, right wrist, left arm, and left leg pain following a work related injury on 10/26/11. The claimant complains of pain and difficulty sleeping. The claimant has a history of left knee arthroscopy, chiropractic care, and physical therapy. The claimant's treatment includes physical therapy and medications. Medications include Hydrocodone three times per week, Advil, Salon pas, Tramadol, Trazodone, and Aspirin. The physical exam was significant for antalgic gait assisted by crutch on the right side, slumped posture, swelling of the left knee, restricted range of motion with flexion limited to 90 degrees due to pain and extension limited to 0 degrees, as well as tenderness to palpation over the medial joint line. The claimant was diagnosed with lumbar radiculopathy, cervicobrachial syndrome, lumbago, cervicalgia, internal derangement of the left knee and myofascial pain syndrome, left sprain meniscus tear, and sprain of left knee and leg nos.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for 60 Naprosyn 500mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

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

Decision rationale: Per the MTUS guidelines, NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associated with cardiovascular disease and gastrointestinal distress. The medical records do not document the length of time the claimant has been on Naprosyn. Additionally, the claimant had previous use of NSAIDs. The medication is therefore not medically necessary. The request is noncertified.

request for 90 Flexeril 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: The peer-reviewed medical literature does not support long-term use of cyclobenzaprine in chronic pain management. Additionally, per the California MTUS, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first four days of treatment, suggesting that shorter courses may be better. As per the MTUS, the addition of cyclobenzaprine to other agents is not recommended. In regards to this claim, cyclobenzaprine was prescribed for long term use and in combination with other medications. Cyclobenzaprine is therefore, not medically necessary. The request is noncertified.

request for Theracane: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: Theracane is a massager that allows a patient to perform self-massage to the spine and paraspinal muscles. The California MTUS and Official Disability Guidelines do not make specific provisions for this device; additionally, there are no peer-reviewed evidence based trials of device. The third edition of the ACOEM guidelines suggest that mechanical devices for administering massage are not recommended; therefore the request for a therapeutic cane is not medically necessary. The request is noncertified.