

Case Number:	CM13-0066097		
Date Assigned:	01/03/2014	Date of Injury:	01/06/2012
Decision Date:	08/29/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/16/2013

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 Anesthesiology, has a subspecialty in Pain 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 66 year old male who had a work-related injury on 01/06/12. An office note dated 09/04/12 indicates the injured worker reports right knee stiffness and strong left knee pain rated 8/10 positive swelling, and positive instability. Right knee revealed a well-healed vertical surgical scar. Tenderness to palpation over the medial patella, and a decreased range of motion with flexion less than 100 degrees were noted. Left knee support brace in place. The plan was to continue with a home exercise program, physical therapy, and medications as prescribed. An office note dated 10/16/12 indicates the injured worker reports left knee pain severe causing difficulty walking. He reports status-post right knee total knee arthroplasty recovering well, mild to moderate pain and clicking. The injured worker is status post total knee replacement on the right, and left knee sprain/strain. The injured worker has a history of hypertension and rule out degenerative joint disease. The plan again was to continue home exercise programs, as prescribed. Most recent office note submitted for review is dated 01/08/13. The patient reports bilateral knee pain moderate to severe left knee pain 5-6/10 greater than right knee pain. Right knee examination revealed low high vertical scar. The injured worker had tenderness to palpation medial patella, and a decreased range of motion with flexion less than 100 degrees. The left knee revealed a vertical surgical scar or surgical tape. There was mild to moderate swelling no redness or discharge.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 7.5MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, muscle relaxant (for pain).

Decision rationale: Flexeril is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. As such, the request is not medically necessary and appropriate.

NAPROXEN 550MG #60: 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 NSAID's Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS Chronic Pain Guidelines do not support the request for Naproxen. It is recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Within the clinical documentation submitted for review, there is no clinical evidence of decreased pain. As such, medical necessity has not been established.

MENTHODERM 120GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, topical analgesics.

Decision rationale: According to the MTUS Chronic Pain Guidelines, Methoderm is considered largely experimental in use with few randomized controlled trials to determine efficacy or safety. Within the clinical documentation submitted for review, there is no clinical evidence of decreased symptoms. Therefore, medical necessity has not been established.