

Case Number:	CM14-0112828		
Date Assigned:	08/01/2014	Date of Injury:	05/01/2013
Decision Date:	09/11/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/20/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 54 year old female was reportedly injured on 5/1/2013. The mechanism of injury is undisclosed. The most recent progress note, dated 5/16/2014, indicates that there are ongoing complaints of neck pain, mid back pain, low back pain, bilateral hip and knee pain. The physical examination demonstrated cervical spine positive tenderness to palpation sub occipital region, trapezius, and scalene muscles, decreased range of motion, positive cervical compression/distraction, sensation is decreased, motor strength is decreased, thoracic spine positive tenderness with muscle spasm over the bilateral thoracic paraspinals, decreased range of motion, lumbar spine positive tenderness to palpation lumbar paraspinal muscles, lumbosacral junction, positive spasms, decreased range of motion, positive straight leg raise at 40 degrees, bilateral hip positive tenderness to palpation at greater trochanter, bilateral knee exam positive tenderness over the medial/lateral joint line and patellar femoral joint, decreased range of motion, slight decreased sensation to light touch, muscle strength 4/5 bilateral lower extremity. No recent diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request had been made for Ketoprofen 20 percent, Cyclobenzaprine 5 percent cream, shockwave therapy and was not certified in the preauthorization process on 6/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20 % cream: Upheld

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

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety, and that any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended. After reviewing the medical documentation provided there is no documentation of intolerance to oral non-steroidal anti-inflammatory drug (NSAIDs). As such, this request is not considered medically necessary.

Cyclobenzaprine 5% cream: Upheld

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

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety. The guidelines further state that the use of topical muscle relaxers, including Cyclobenzaprine, is not recommended. As such, this request is not considered medically necessary.

Shockwave Therapy (Unknown body part): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic). Shockwave therapy, Updated 8/22/2014.

Decision rationale: According to Official Disability Guidelines (ODG) guidelines shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms the treatment is not justified. After reviewing guideline recommendations this request is deemed not medically necessary.