

Case Number:	CM15-0054870		
Date Assigned:	03/30/2015	Date of Injury:	08/26/2009
Decision Date:	05/06/2015	UR Denial Date:	02/21/2015
Priority:	Standard	Application Received:	03/23/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old male, who sustained an industrial injury on 8/26/2009. He reported a specific injury, evaluated urgently and diagnosed with a scapholunate tear and ulnar styloid fracture. He underwent surgical intervention in April 2010. He is also status post right medial elbow surgery 2012, right shoulder surgery 2012, and repeat right elbow surgery in 2013. Diagnoses include cervical disc herniation, right neural foraminal narrowing, cervical radiculopathy, arthralgia, chronic low back pain, lumbar radiculopathy, lumbar herniation, cervical myofascial pain and left sacroiliitis. Treatments to date include medication therapy, physical therapy, chiropractic therapy, acupuncture, trigger point injections and epidural injections. Currently, he complained of ongoing neck, mid and low back, and bilateral knees and shoulder pain associated with numbness in upper extremities and right greater than left lower extremities. On 2/26/15, the physical examination documented decreased range of motion in cervical and lumbar spine with decreased sensation in right C4, right L5 and S1 dermatomes. The plan of care included continuation of medication therapy and a right S1 joint injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine cream 5% 1 tube: Upheld

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

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

Decision rationale: The patient presents with pain affecting the neck, mid back, low back, bilateral knees and shoulder with radiation to the bilateral upper and lower extremities. The current request is for Cyclobenzaprine cream 5% 1 tube. The treating physician report dated 2/26/15 (4B) states, "His pain decreased to 6/10 from 8/10 with the pain medications and he is able to do more activities such as household duties for a little while longer." The MTUS guidelines state, "There is no evidence for use of any other muscle relaxant as a topical product." In this case, even though the patient has experienced some pain relief from the use of this medication, Cyclobenzaprine is a muscle relaxant and is not recommended as a topical product by the MTUS guidelines as outlined on page 113. The request is not medically necessary and recommendation is for denial.