

<b>Case Number:</b>	CM13-0040203		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	12/07/2010
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Acupuncture and Pain Medication 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 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:

This case involves a 24-year-old female injured worker, with date of injury 12/7/10 with related left shoulder pain. She is diagnosed with chronic neck pain with a disc osteophyte complex at C4-C5, left shoulder pain, chronic low back pain with multiple disc protrusions, as well as comorbid complaints of depression, anxiety, and difficulty sleeping. An MRI dated 1/1/11, revealed left shoulder strain, bursitis, tendinitis, impingement, and glenoid labrum tear. According to the MRI of the cervical spine dated 11/18/11, there was muscle sprain and strain with left upper extremity radiculopathy; and 1-1.5 mm disc osteophyte at C5-C6. A positive nerve conduction study dated 9/12/11 revealed left wrist carpal tunnel syndrome. Per the 9/18/13 evaluation, the left shoulder showed limited active range of motion in all planes due to pain. A shoulder depression test, cross arm test and subacromial push button tests were all positive. She was refractory to acupuncture, physical therapy, aquatic therapy, cortisone injection, and medications. The date of the utilization review (UR) decision was 10/18/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren XR 100mg #30, one (1) by mouth daily:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific d.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68 and 71.

**Decision rationale:** The Chronic Pain Guidelines indicate that non-steroidal anti-inflammatory drugs (NSAIDs ) have "fewer effects than muscle relaxants and narcotic analgesics." The guidelines also indicate that Voltaren®-XR should only be used as chronic maintenance therapy. According to the 10/9/13 report, the injured worker complained of continued left shoulder pain, which was at an average level of 8/10 and was reduced to 4/10 with the help of medications. However, she noted that at worst, the pain level increased to severe and interfered with all left upper extremity activities. Her symptoms interfered with activities of daily living, especially activities with the left hand. There is no documentation of gastrointestinal (GI) side effects. As this medication is to be used for chronic maintenance therapy, and reduces pain by 50%, it is being used appropriately. The request is medically necessary.

**Zanaflex 4mg #60, one (1) by mouth two (2) times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs Page(s): 66.

**Decision rationale:** The Chronic Pain Guidelines indicate that "Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. May also provide benefit as an adjunct treatment for fibromyalgia." According to the guidelines, tizanidine is supported for the use of low back pain and myofascial pain. The injured worker is not being treated for these diagnoses. There is no documentation stating how this medication specifically helps shoulder pain. Without clear indication from the guidelines or the documentation, medical necessity cannot be established.