MAXIMUS Federal Services

Case Number:	CM13-0064682		
Date Assigned:	01/03/2014	Date of Injury:	12/30/2003
Decision Date:	08/15/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/12/2013

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 Internal 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 58 year old woman with diagnoses of shoulder pain, radiculopathy, low back pain (chronic) and bilateral carpal tunnel syndrome along with depression. The submitted documentation by the primary treating physician reports on 11/19/2013 that the injured worker has shoulder pain with a positive Hawkin's maneuver and limited abduction. In notations from 9/10/2013 and 9/17/2013 the injured worker is documented to have tenderness over the bicipital grooves, the acromioclavicular joints and the subdeltoid bursae bilaterally. Motor examination was limited by pain. She has limited range of motion in both flexion and abduction. She was also noted to have low back pain which was worse compared to before, with interruption of sleep and no change in activity patterns. The injured worker also reported pain localized to the left knee with tenderness over the joint line, patella and hamstrings. There was paravertebral muscle spasm and facet loading produced a positive result. The plan of care was for Lexapro, Pristiq, Voltaren gel 1%, Oxycodone/aceteminophen and Flexeril along with bilateral epidural steroid injections at the L5 level. Prior imaging and investigational studies revealed minimal supraspinatus tendinopathy of the right shoulder, minimal disk disease in the lumbar and lower thoracic spine without neural impingement or myelopathy and electrodiagnostic studies (EMG/NCV) done to establish the diagnosis of bilateral carpal tunnel syndrome treated previously with tunnel release. Requests to be reviewed include the appropriateness of Flexeril and Voltaren gel 1%.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Section - Clinical Measures, Subsection - Muscle relaxers.

Decision rationale: As indicated by the utilization reviewer, the injured worker is being treated with Flexeril on a chronic basis and this is not supported by the MTUS document. Flexeril (cyclobenzaprine) is a centrally active agent which produces long term tolerance and dependence, has the potential of abuse, can be associated with respiratory depression when used concurrently with opiates and benzodiazepines, and results in the risk of seizures when abruptly discontinued or doses are inadvertently missed. With these considerations in mind, most authorities including the MTUS do not recommend chronic use of cyclobenzaprine. Additionally, and quite significantly, there isn't evidence that the objective and subjective functioning or quality of life of patients is improved by this medication. As such, its use should be strongly discouraged. The provider's documentation submitted for review did not indicate the rationale for use. As such, the continuation of this medication is not in the best interest of the patient and is not medically necessary.

VOLTAREN 1% GEL 100G #6: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: There is no recommendation for or against using topical medications for shoulder and low back disorders per ACOEM. The tissues being treated are not known to be superficial enough to be amenable to topical therapy. Nonetheless, if topical therapy results in pain relief, given that the active agent is an NSAID, and would likely have fewer side effects when applied topically than when applied systemically, a trial of 100 gm of Voltaren 1% is reasonable. However, there was no clear documentation of a response to this intervention to establish medical necessity. As such, the request is not medically necessary.