

Case Number:	CM14-0143628		
Date Assigned:	09/12/2014	Date of Injury:	06/07/2007
Decision Date:	11/05/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/04/2014

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, 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 63-year-old male who reported an injury on 06/07/2007. The mechanism of injury was not submitted for review. The injured worker had diagnoses of cervical disc injury, strain, and radiculopathy; lumbar disc injury, strain, and radiculopathy; and labral sprain of the right shoulder. The injured worker's medications consist of Voltaren gel and Flexeril. There were no pertinent diagnostics or past medical treatments submitted for review. On 08/12/2014, the injured worker complained of neck and back pain. It was noted that the injured worker had bilateral seated straight leg raise at 90 degrees with no referral to lower extremities. Motor strength was 5/5 throughout both lower extremities. There was tenderness over the bilateral L4-5 more than L5-S1 level. Sensibility was intact in both lower extremities. Kemp's sign was negative. Range of motion revealed forward flexion of 60 degrees with moderate pain going from flexion to extension, extension was at 25 degrees with slight pain, bilateral lateral flexion was 45 degrees with slight pain bilaterally, and bilateral rotation was 35 degrees. The treatment plan is to continue the use of medications. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel bid topically #1 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

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

Decision rationale: The request for Voltaren gel is not medically necessary. The California MTUS state that Voltaren gel is an FDA approved agent indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Maximum dose should not exceed 32 gm per day (8 gm per joint per day in the upper extremity and 16 gm per joint per day in the lower extremity). Given the above, the use of Voltaren gel is not recommended by the MTUS for the use of spine, hip, or shoulder. The submitted documentation did not indicate that the injured worker had pain in the ankle, elbow, foot, hand, knee, or wrist. Furthermore, the request as submitted did not specify where the Voltaren gel would be used. As such, the request is not medically necessary.

Flexeril 10mg po qhs #30 with 6 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41-42.

Decision rationale: The decision for Flexeril 10 mg is not medically necessary. The California MTUS Guidelines recommend Flexeril as an option for a short course of therapy. The greatest effect of this medication is in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The request for Flexeril 10 mg #30 with 6 refills exceeds the Guideline recommendations for short term therapy. Additionally, the submitted documentation did not indicate the efficacy of the medication. There was also no indication that the Flexeril was helping the injured worker with any functional deficits. The provider's rationale was not submitted for review. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.