

Case Number:	CM14-0171778		
Date Assigned:	10/23/2014	Date of Injury:	09/07/2007
Decision Date:	12/31/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/16/2014

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 Occupational 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:

This is a 58-year-old female with a 9/7/07 date of injury. The mechanism of injury occurred as the result of repetitive lifting of boxes between 25 to 50 pounds. According to a progress report dated 7/24/14, the patient complained of achy, cramping, sharp pain across the neck and shoulders and lower back areas, rated as an 8-9/10. She has been having ongoing problems with lying on the right shoulder because of pain. Objective findings: pain limited active range of movement (AROM) of the right shoulder; pain limited AROM of lumbar spine, paresthesias in digits 1 through 3 on the right and along the lateral aspect of the legs. Diagnostic impression: cervicobrachial syndrome, adhesive capsulitis of the right shoulder, bilateral bicipital tenosynovitis, chronic low back pain. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 10/10/14 denied the request for Voltaren gel and modified the request for Orphenadrine ER to certify a 1-month supply for weaning purposes. Regarding Voltaren, there is no documentation of a diagnosis of osteoarthritis or tendinitis for this claimant. The treating provider does not provide a rationale as to why the claimant requires topical non-steroidal anti-inflammatory drugs (NSAIDS) versus traditional oral agents. Regarding Orphenadrine ER, there are no progress notes included for review documenting the date this medication was initiated, duration of treatment, physical examination consisting of muscle spasm, or any functional benefit as a result of use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine ER 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 63-66.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in lower back pain (LBP) cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. However, in the present case, there is no documentation of spasms in the medical records provided for review. In addition, there is no documentation that this patient has had an acute exacerbation to her pain. It is unclear how long the patient has been taking orphenadrine, and guidelines do not support its long-term use. Therefore, the request for Orphenadrine ER 100mg #30 was not medically necessary.

Voltaren 1% Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. However, in the present case, there is no documentation that this patient has a diagnosis of osteoarthritis. In addition, there is no documentation that she is unable to tolerate an oral NSAID medication. Therefore, the request for Voltaren 1% Gel was not medically necessary.