

Case Number:	CM14-0023699		
Date Assigned:	05/12/2014	Date of Injury:	02/22/2010
Decision Date:	12/11/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/24/2014

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 Neurology and is licensed to practice in Texas, Massachusetts and Ohio. 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 46-year-old male who reported an injury on 02/22/2010 due to an unknown mechanism. Diagnosis was status post lumbar laminectomy. Physical examination on 03/14/2014 revealed that the injured worker was reported as feeling poorly. It was reported that the injured worker had not used any pain medications for the last month, and he continued with the Soma twice a day. There were complaints of low back pain with occasional spasm into the buttocks and the injured worker continued to report spasm and swelling in his low back. The injured worker reported that he felt it was his hardware that caused the pain and swelling. Last procedure was in 09/2013. Examination revealed no edema in the low back. There was mild tenderness to palpation over the superior aspect of the incision. Strength was 5/5 in bilateral lower extremities. Treatment plan was to start Celebrex 200 mg daily, Zanaflex for spasm and Voltaren gel for inflammation. The rationale and Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg, #90: 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 Tizanidine Page(s): 66.

Decision rationale: The decision for Zanaflex 4mg, #90 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend tizanidine (Zanaflex) as a nonsedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The long term use of this medication should be based on measurements of pain relief and documented functional improvement. The physical examination submitted for review was dated 03/14/2014. There were no updated clinical notes submitted. This medication is recommended for a short term treatment of acute exacerbations. It is unknown if the injured worker is having an acute exacerbation currently, due to the fact the most recent note was dated for 03/2014. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel 1% Page(s): 111.

Decision rationale: The decision for Voltaren gel 1% is not medically necessary. The California Medical Treatment Utilization Schedule states Voltaren gel 1% (diclofenac) 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 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical note dated 03/14/2014 did not indicate where the injured worker was to use this medication. It was also not reported that the injured worker had a diagnosis of osteoarthritis pain. The request does not indicate a frequency or quantity for the medication. The clinical information submitted for review does not provide evidence to justify continued use of Voltaren gel 1%. Therefore, this request is not medically necessary.