MAXIMUS Federal Services

Case Number:	CM14-0070454		
Date Assigned:	07/14/2014	Date of Injury:	03/24/2009
Decision Date:	09/09/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/15/2014

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:

The patient is a 53 year old female who was injured on 03/24/2009 while she was pulling and reaching for a bin. Prior medication history included Tramadol, Xoten-C lotion and Naproxen.Progress report dated 04/02/2014 documented the patient complained of persistent bilateral upper extremity pain in both shoulders with associated burning. She rated her pain as 6/10; burning pain in both wrist rated as 7/10. She also complains of aching in the left elbow. Objective findings on exam revealed erythema of the right shoulder with tenderness about the anterior deltoid and biceps muscles. She has mild tenderness about the acromioclavicular joint. Range of motion revealed active abduction to 170 degrees; passive is 170 degrees; external rotation is 90 degrees. Motor muscle strength is 5/5 in all muscle planes. The left elbow revealed positive Tinel's sign at the cubital tunnel. Range of motion revealed flexion to 120 degrees and extend to 0 degree. The right wrist revealed positive Phalen's and Tinel's sign. Diagnoses are right shoulder pain following rotator cuff repair and subacromial decompression with Mumford procedure on 11/17/2009; left shoulder impingement syndrome with acromioclavicular joint pain; left first carpometacarpal joint pain; left cubital tunnel syndrome; right recurrent carpal tunnel syndrome; and left tennis elbow. She has been prescribed Naproxen 500 mg #90, Ultram 50 mg #90, Tizanidine 4 mg #60 for spasm, which there is no mention of, and Voltaren cream 100 gm as topical agent for pain. Prior utilization review dated 04/28/2014 states the request for Voltaren cream 100gm is denied as there is no evidence to support the request. The request for Tizanidine 4mg #60 is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren cream 100gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics.

Decision rationale: According to MTUS guidelines, topical non-steroidal anti-inflammatory drugs (NSAIDs) may be recommended for short-term treatment of 4-12 weeks for osteoarthritis or tendinitis typically after a failure of first-line oral NSAIDs, in joints amenable to topical treatment. In this case a request is made for Voltaren cream for a 53-year-old female injured on 3/24/09 with chronic pain, bilateral shoulder impingement, neck, strain, bilateral carpal tunnel syndrome, and left cubital tunnel syndrome. However, the patient is concurrently prescribed Naproxen. Furthermore, while she is diagnosed with left hand CMC pain, osteoarthritis of the hand is not clear by provided history or examination. Topical NSAIDS are not recommended for the shoulders or spine. As such, this request is not medically necessary.

Tizanidine 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Muscle relaxants.

Decision rationale: According to MTUS guidelines, muscle relaxants are recommended for short-term treatment of acute exacerbations of chronic low back pain. Long-term use is not recommended as efficacy appears to diminish over time. There does not appear to be additional benefit when combined with non-steroidal anti-inflammatory drugs (NSAIDs). In this case, a request is made for Tizanidine for a 53-year-old female injured on 3/24/09 with chronic pain, bilateral shoulder impingement, neck, strain, bilateral carpal tunnel syndrome, and left cubital tunnel syndrome. However, long-term use of muscle relaxants is not recommended and muscle spasms are not noted. In addition, history and examination findings do not demonstrate exceptional circumstances. Clinically significant functional improvement from use of Tizanidine is not evident. Therefore, the request is not medically necessary.