

Case Number:	CM14-0207862		
Date Assigned:	12/19/2014	Date of Injury:	01/06/2010
Decision Date:	02/12/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/11/2014

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 Anesthesiology, 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 69-year-old male who reported an injury on 01/06/2010. The mechanism of injury was due to a trip and fall. The injured worker has diagnoses of cervical/trapezial musculoligamentous sprain/strain and bilateral upper extremity radiculitis, lumbar musculoligamentous sprain/strain and bilateral lower extremity radiculitis, left shoulder parascapular strain with bursitis, impingement syndrome, and moderate to severe acromioclavicular joint degenerative changes, status post partial knee replacement, and right knee medial compartment with patellofemoral arthralgia and slight degenerative changes, left wrist symptoms, and chronic right ankle pain and history of instability. Past medical treatments consisted of surgery, therapy, and medication therapy. Medications consist of Tylenol with codeine, Fexmid, and Voltaren gel. No urinalysis or drug screens were submitted for review. On 11/03/2014, the injured worker complained of right knee, low back, left shoulder, neck, left wrist, and right ankle pain. His physical examination noted sensation to pinprick and light touch was decreased in the left upper extremity in the C6, C7, and C8 dermatomal distributions. Sensation to pinprick and light touch was decreased in the bilateral lower legs and feet in a patchy, non-dermatomal distribution. There was atrophy of the right distal quadriceps musculature as measured. The deep tendon reflexes of the biceps, triceps, and brachial radialis were 1+ bilaterally. Deep tendon reflexes of the knee jerk and ankle jerk were 1+ bilaterally. There was tenderness to palpation noted over the paravertebral musculature and trapezius muscles. There was also tenderness noted over the subacromial region, anterior capsule, and acromioclavicular joint. The medical treatment plan is for the injured worker to continue with medication therapy. The provider noted that the Voltaren gel would be applied to the right knee 3 times a day for pain and Fexmid 1 tablet twice a day for muscle spasm. The Request for Authorization Form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5 mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Fexmid) Page(s): 41.

Decision rationale: The request for Fexmid 7.5 mg #20 is not medically necessary. The California MTUS Guidelines recommend Fexmid 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. It appears that the injured worker has been on the medication since at least 11/03/2014. Additionally, the submitted documentation lacked efficacy of the medication, and there was no indication of muscle spasm on physical examination. Given the above, the injured worker is not within guideline criteria. As such, the request is not medically necessary.

Voltaren Gel (one tube) to be applied to the right knee three times a day for pain and inflammation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC Pain Procedure Summary

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

Decision rationale: The request for Voltaren gel (one tube) to be applied to the right knee three times a day for pain and inflammation is not medically necessary. The California MTUS Guidelines state Voltaren gel 1% (diclofenac) has an FDA appropriation indicated for the 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. The maximum dose should not exceed 32 g per day. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits the injured worker had to the knee. Furthermore, the request as submitted did not specify a dosage for the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.