

Case Number:	CM15-0102525		
Date Assigned:	06/04/2015	Date of Injury:	04/12/1999
Decision Date:	07/17/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	05/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Arizona, California
 Certification(s)/Specialty: Family Practice

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 65-year-old male, who sustained an industrial injury on April 12, 1999. He reported an injury to his neck and shoulders. Treatment to date has included Naprosyn, occasional indomethacin for gout, MRI of the cervical and lumbar spine, Sanders cervical traction unit, surgical consultation, physical therapy and cervical fusion. Currently, the injured worker complains of continued neck and bilateral shoulder pain. He reported new complaints of burning pain with associated numbness and tingling of his neck. He reports radiation of pain to the bilateral upper extremities. On physical examination, the injured worker has positive impingement signs bilaterally of the shoulders with positive supraspinatus motor testing bilaterally. His range of motion is limited in both shoulders. He has tenderness to palpation over the cervical spine and extending into the bilateral trapezia. A Spurling's maneuver was positive on the right and his cervical range of motion was reduced in all planes. An MRI of the cervical spine on February 3, 2015 revealed degenerative changes, multiple areas of moderate-to-severe neuroforaminal stenosis, and mild-to-moderate central canal narrowing at C4-5. The diagnoses associated with the request include bilateral shoulder impingement syndrome, chronic cervicgia, cervical degenerative disc disease, and cervical radiculitis. His treatment plan includes continuation of Zanaflex, Voltaren and neurosurgical consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Voltaren topical 1% gel Qty: 3 Refills: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is a topical analgesic. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant was prescribed the gel with additional 3 months refill is not indicated. The claimant did not have the above diagnoses. There are diminishing effects after 2 weeks. The Voltaren gel is not medically necessary.

Zanaflex 4mg oral capsule Qty: Refills: Not stated: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs Page(s): 66 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63.

Decision rationale: According to the MTUS guidelines, Zanaflex is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. It falls under the category of muscle relaxants. According to the MTUS guidelines, muscle relaxants are to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the claimant had been on muscle relaxants the prior month. Continued and chronic use of muscle relaxants /antispasmodics is not medically necessary. Therefore, Zanaflex is not medically necessary.