

Case Number:	CM15-0107124		
Date Assigned:	06/16/2015	Date of Injury:	04/04/2011
Decision Date:	07/15/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/04/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58-year-old female with an industrial injury dated 04/04/2011. The injured worker's diagnoses include multilevel herniated nucleus pulposus of the cervical spine, multilevel canal stenosis, multilevel cervical neural foraminal narrowing, right carpal tunnel syndrome, right shoulder subacromial bursitis, right shoulder impingement, cervicogenic headaches, cervical facet arthropathy, mechanical neck pain and status post bilateral CRFA (cervical radiofrequency ablation) at C5-7. Treatment consisted of diagnostic studies, prescribed medications, cortisone injections, transcutaneous electrical nerve stimulation (TENS) unit and periodic follow up visits. In a progress note dated 05/07/2015, the injured worker presented for follow-up of neck and bilateral upper extremity symptoms, right shoulder pain and headaches. The injured worker rated neck pain a 4-7/10. Objective findings revealed tenderness with hypertonicity of the paracervical musculature, tenderness to palpitation over the bilateral cervical facets at C3-7, right greater than left, positive facet joint loading at C5-7 and limited range of motion. Right shoulder exam revealed decreased range of motion, pain to palpitation in the acromioclavicular joint (AC) joint, positive subacromial bursitis and decrease motor exam secondary to pain. The treating physician prescribed Compound Caps .05% and Cyclo 4% and Zanaflex 4mg #30 now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Caps .05% and Cyclo 4%: 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): 111-113.

Decision rationale: Regarding the request for topical cyclobenzaprine as a component, CA MTUS states that topical muscle relaxants are not recommended, as there is no peer-reviewed literature to support the use of topical baclofen or any other muscle relaxant as a topical product. Furthermore, the same guidelines specify that if one component of a compounded medication is not recommended, then the entire formulation is not recommended. Given these guidelines, this request is not medically necessary.

Zanaflex 4mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Tizanidine (Zanaflex).

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

Decision rationale: Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification appropriate liver function testing, as recommended by guidelines. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. This worker has long-standing chronic pain. Given this, the currently requested tizanidine (Zanaflex), is not medically necessary.