MAXIMUS Federal Services

Case Number:	CM15-0192184		
Date Assigned:	10/06/2015	Date of Injury:	01/13/2006
Decision Date:	11/18/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	09/29/2015

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

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 52 year old female, who sustained an industrial injury on 1-13-2006. The injured worker is being treated for chronic major depression with current and prior suicidal ideation, chronic lumbosacral strain with right lumbar myelopathy, chronic cervical strain and disc herniation, and adhesive capsulitis right shoulder. Treatment to date has included diagnostics, TENS, physical therapy, medications and injections. Per the Orthopaedic Physician's Progress Report dated 9-14-2015 the injured worker reported improved but continued major depression. The documentation states that on prior visits dated 6-09-2015 and 7-13-2015 she reported "I'm still suicidal." She also reported worsened lower back pain, neck pain, and left greater then right shoulder pain and stiffness. Objective findings included diffuse fibromyotic trigger point pains. There was tenderness, spasm and decreased range of motion of the neck. The right shoulder was painful with spasm and swelling. The lower back had muscle spasm, pain and tenderness. The notes from the provider do not document efficacy of the prescribed medications. Work status was totally disabled. The plan of care included, and authorization was requested for Voltaren cream 1%, ongoing consult and treatment for suicidal ideation and Robaxin 500mg #150. On 9-21-2015, Utilization Review non-certified/modified the request for Voltaren cream 1%, ongoing consult and treatment for suicidal ideation and Robaxin 500mg #150.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren cream 1% apply four times a day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents with pain in the low back, neck, bilateral shoulders, and depression. The request is for VOLTAREN CREAM 1% APPLY FOUR TIMES A DAY AS NEEDED. Physical examination to the cervical spine on 09/14/15 revealed tenderness to palpation to the bilateral trapezii muscles with spasm. Range of motion was noted to be decreased. Examination to the lumbar spine revealed tenderness to palpation and positive straight leg raising test at 40 degrees. Patient's treatments have included medication, TENS unit, ESI's, aqua therapy, and physical therapy. Per 09/14/15 Request For Authorization form, patient's diagnosis include lumbar spondylosis with anxiety and depression, cervical IVDD w myelopathy, major depression, and LS IVDD with myelopathy. Patient's medications, per 07/13/15 progress report include Voltaren Gel, and Lidoderm Patch. Patient is permanently disabled and stationary. MTUS Chronic Pain Medical Treatment Guidelines 2009, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." "This class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): 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. The treater has not addressed this request. Review of the medical records provided indicate that the patient was prescribed Voltaren Cream 1% from 05/11/15 through 09/14/15.
However, the treater has not discussed how Voltaren Gel decreases pain and significantly improves patient's activities of daily living. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Furthermore, the guidelines do not support the use of this medication for shoulder problems. The request IS NOT medically necessary.

Ongoing consult and treatment for suicidal ideation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Cognitive therapy for depression.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, page 127.

Decision rationale: The patient presents with pain in the low back, neck, bilateral shoulders, and depression. The request is for ONGOING CONSULT AND TREATMENT FOR SUICIDAL IDEATION. Physical examination to the cervical spine on 09/14/15 revealed tenderness to palpation to the bilateral trapezii muscles with spasm. Range of motion was noted to be decreased. Examination to the lumbar spine revealed tenderness to palpation and positive straight leg raising test at 40 degrees. Patient's treatments have included medication, TENS unit, ESI's, aqua therapy, and physical therapy. Per 09/14/15 Request For Authorization form, patient's diagnosis include lumbar spondylosis with anxiety and depression, cervical IVDD w myelopathy, major depression, and LS IVDD with myelopathy. Patient's medications, per 07/13/15 progress report include Voltaren Gel, and Lidoderm Patch. Patient is permanently disabled and stationary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, Chapter 7, Independent Medical Examinations and Consultations Chapter, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Treater has not specifically discussed this request. In this case, the patient continues to suffer from low back pain, neck pain, and pain in the bilateral shoulders, and depression. Per 09/14/15 progress report, patient's diagnosis includes chronic major depression with current [today] and prior suicidal ideation. The ACOEM Guidelines support the referral of patients to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The patient would appear to benefit from psychological treatments but the request is vague and non-specific. It is not known what the requested treatments entail, and does not specify how many sessions if the request is for cognitive behavioral therapy. The treater does not discuss the request on progress reports. The request as stated IS NOT medically necessary.

Robaxin 500mg (1-2) four times a day as needed #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The patient presents with pain in the low back, neck, bilateral shoulders, and depression. The request is for ROBAXIN 500MG (1-2) FOUR TIMES A DAY AS NEEDED #150. Physical examination to the cervical spine on 09/14/15 revealed tenderness to palpation to the bilateral trapezii muscles with spasm. Range of motion was noted to be decreased. Examination to the lumbar spine revealed tenderness to palpation and positive straight leg raising test at 40 degrees. Patient's treatments have included medication, TENS unit, ESI's, aqua therapy, and physical therapy. Per 09/14/15 Request For Authorization form, patient's diagnosis include lumbar spondylosis with anxiety and depression, cervical IVDD w myelopathy, major depression, and LS IVDD with myelopathy. Patient's medications, per 07/13/15 progress report

include Voltaren Gel, and Lidoderm Patch. Patient is permanently disabled and stationary. MTUS chronic pain guidelines 2009, pages 63-66 for Muscle Relaxants (for pain) section states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. MTUS, pages 63-66, under antispasmodics for methocarbamol (Robaxin, Relaxin, generic available) states: The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. In progress report dated 09/14/15, the treater is prescribing Robaxin for pain relief and restoration of function. Review of the medical records provided did not indicate prior use and it appears that the treater is initiating this medication. The patient is suffering from chronic low back, neck, and bilateral shoulder pain. In this case, the treater does not indicate this medication is to be used for short-term. MTUS guidelines do not supports long term use of this medication due to sedative effect. The requested 150 tablets does not imply short-term therapy. Therefore, the request IS NOT medically necessary.