

Case Number:	CM15-0035246		
Date Assigned:	03/03/2015	Date of Injury:	04/01/2004
Decision Date:	04/14/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/25/2015

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: Texas, 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:

This is a 61-year-old female patient who sustained a work related injury on 04/01/2004. Diagnoses included other chronic pain and lumbago. According to the Doctor's First Report of Injury dated 01/21/2015, she had complaints of low back pain with decreased range of motion and spasm. The medications list includes Voltaren Gel, Zanaflex, Motrin and Norco. She has undergone lumbar surgery on 11/12/2008. She has had lumbar and cervical MRI on 1/25/2010. She has had physical therapy visits, acupuncture and massage for this injury. On 02/09/2015, Utilization Review non-certified Voltaren Gel 1% and Zanaflex 4mg #60. According to the Utilization Review physician, in regard to Voltaren Gel, it was unclear if the injured worker had underlying osteoarthritis and whether there had been benefit from this medication. CA MTUS Chronic Pain Medical Treatment Guidelines, page 112 was cited. In regard to Zanaflex, while the most recent medical report identified spasms, there was no indication that there were chronic. There was no indication of efficacy of this medication and no rationale of chronic use of muscle relaxants. CA MTUS Chronic Pain Medical Treatments Guidelines, page 63 was referenced. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%: Upheld

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

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) Chapter: Pain (updated 04/06/15) Voltaren 1/2 Gel (diclofenac).

Decision rationale: Request: Voltaren Gel 1%. The cited guidelines regarding topical analgesics state, "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." Any intolerance or contraindication to oral medications is not specified in the records provided. The cited guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Response to antidepressants and anticonvulsants is not specified in the records provided. In addition, per the ODG cited above Voltaren Gel is, "Not recommended as a first-line treatment. See Diclofenac Sodium (Voltaren), where Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations." The medical necessity of Voltaren Gel 1% is not established for this patient at this time.

Zanaflex 4mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-sedating muscle relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs: Tizanidine (Zanaflex) Page(s): 66.

Decision rationale: Request: Zanaflex 4mg #60. According to MTUS guidelines, "Tizanidine (Zanaflex, generic available) 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 (Chou, 2007). One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. May also provide benefit as an adjunct treatment for fibromyalgia." The patient has chronic back pain with restricted range of motion and spasm. She has a history of lumbar fusion surgery. Tizanidine is recommended for chronic myofascial pain. The request of Zanaflex 4mg #60 is deemed medically appropriate and necessary for this patient.