

<b>Case Number:</b>	CM15-0040764		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	05/18/2010
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 62 year old female, who sustained an industrial injury on 5/18/2010. She reported complaints of chronic pain syndrome that includes pain in right shoulder, arms, forearm, elbow, wrist, hand and fingers. The documentation indicates this pain interferes with sleep, causes headaches and depression. The injured worker reports she has been without pain medications for four-six months and symptoms are worse without the medication and has been taking over the counter NSAIDs for pain relief. The injured worker was diagnosed as having cervical herniated disc; displacement cervical intervertebral disc without myelopathy; disorders of the bursae and tendons in shoulder region, unspecified; chronic pain syndrome. Treatment to date has included physical therapy; home exercise program; surgery on the right shoulder (no date); psychology sessions; medications. Currently, the injured worker complains of right upper extremity pain that includes shoulder to fingers and has been taking only over the counter medications since prescribed medications have been denied on the claim. Documentation indicates the injured worker is not a candidate for future surgery on the right upper extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren XR 100 mg #30 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NONSELECTIVE NSAIDS Page(s): 107.

**Decision rationale:** According to MTUS guidelines, Diclofenac Sodium is used for osterarthrits pain. There is no documentation of the efficacy of previous use of the drug. There is no documentation of monitoring for safety and adverse reactions of the drug. There is no documentation that the patient developed osteoarthritis. Therefore, the request for Voltaren XR 100mg Qty: 30 with 3 refills is not medically necessary.

**Retrospective Tizanidine 4 mg #30 with 3 refills, given 1/23/15,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

**Decision rationale:** According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient was previously treated with Tizanidine for at least 4 months, which is considered a prolonged use of the drug. There is no continuous and objective documentation of the effect of the drug on patient pain, spasm and function. There is no recent documentation for recent pain exacerbation or failure of first line treatment medication. Therefore, the request for retro Tizanidine 4mg #30, with 3 refills is not medically necessary.