

Case Number:	CM14-0160124		
Date Assigned:	10/03/2014	Date of Injury:	02/01/2008
Decision Date:	10/30/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	09/29/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59-year-old male who reported an injury on 02/01/2008 due to an unknown mechanism. Diagnoses were status post cervical spine fusion, lumbosacral strain/sprain rule out disc herniation, bilateral rotator cuff syndrome, bilateral wrist sprain/strain, and multiple nonorthopedic issues. Physical examination dated 09/02/2014 revealed complaints of neck, right shoulder, bilateral wrists, and lower back pain. Pain was reported to be 9/10 for the neck. Right shoulder pain was rated 9/10. Wrist pain was rated 9/10, and lower back and left wrist was rated 7/10. Examination of the cervical spine revealed decreased range of motion. Spurling's was positive bilaterally. Examination of the lumbar spine revealed decreased range of motion. There was tenderness to the paraspinals. Kemp's sign was positive bilaterally, straight leg raise was positive bilaterally at 70 degrees to posterior thigh. Examination of bilateral shoulders revealed significant decreased range of motion symmetrically. Neer's and Hawkin's impingement tests were positive. Examination of bilateral wrists revealed decreased range of motion with decreased sensation at the median and ulnar nerve distributions bilaterally. The treatment plan was to continue medications as directed and physical therapy 2 times a week for 4 weeks. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baclofen 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/dosage/baclofen.html> Pain, Muscle Relaxants

Decision rationale: The decision for baclofen 100 mg, quantity 60, is not medically necessary. The Official Disability Guidelines state that baclofen is recommended as a nonsedating muscle relaxants with caution as a second line option for short term (less than 2 weeks) treatment of acute low back pain and for short term treatment of acute exacerbation in patients with chronic low back pain. The request does not indicate a frequency for the medication. The medical guidelines state that the use of this medication is only for 2 to 3 weeks. Drugs.com was referenced; Baclofen 40-80mg/day as maintenance dose. If on 80mg/day it should be administered in 4 divided doses. Baclofen 100mg twice daily is not recommended due to overdose. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Voltaren gel 100g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel 1% Page(s): 111.

Decision rationale: The decision for Voltaren gel 100 gm is not medically necessary. The California Medical Treatment Utilization Schedule states Voltaren gel 1% (diclofenac) is an FDA approved agent indicated for relief of osteoarthritis pain in the joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Maximum dose should not exceed 32 gm per day (8 gm per joint per day in the upper extremity and 16 gm per joint per day in the lower extremity). The request does not indicate what part of the body this medication is to be used on. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.