

Case Number:	CM14-0180443		
Date Assigned:	11/05/2014	Date of Injury:	07/18/2011
Decision Date:	12/16/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/30/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 52-year-old male who sustained an injury on 7/18/11. As per the 10/3/14 appeal letter, he presented with chronic low back pain and right UE pain. As per the 9/2/14 report, he rated the pain at 8-10/10. Exam from this visit revealed tenderness to palpation of the lumbosacral junction, decreased ROM of the L-spine by 20%, and tenderness to palpation of the lumbar facet joints bilaterally. L-spine MRI dated 12/2011 revealed grade 1 retrolisthesis of L5 on S1, mild spinal canal encroachment, and foraminal stenosis at L4-L5 and L5-S1. Right wrist MRI (unknown date) revealed chondromalacia of the head of the ulna but no evidence of significant fracture or impaction syndrome that would require surgical treatments. There was no relevant surgical history. He is currently taking Tramadol, Tizanidine and topical diclofenac sodium. He had right radio-ulnar joint injection on 5/21/14. He takes Tramadol/APAP for pain relief. He uses Zanaflex for muscle spasms intermittently at night which allows him to sleep and it reportedly decreases the intensity and severity of his muscle spasms and he has improvement in function. He has tried Flexeril in the past but it was not so effective. The provider feels that without Zanaflex, the patient would suffer from a lot of muscle tension causing to increase other medications and consider other expensive procedures. He is using diclofenac sodium intermittently for anti-inflammation and pain relief and finds it extremely helpful in terms of topical relief of pain and improvement of function. He is currently on Naproxen. He has tried Relafen in the past which was not beneficial, and he is allergic to Ibuprofen. He feels that topical diclofenac is better than using oral NSAIDs as this prevents the formation of peptic ulcers and gastritis. It also prevents escalation of Naproxen at this time thus preventing subsequent side effects. Diagnoses include pain in joint forearm - right distal ulna, lumbar spine stenosis, sacrum disorders, and sciatica. The request for 1 Prescription for diclofenac sodium 1.5 percent 60 grm #1 and 1 Prescription for tizanidine-Zanaflex 4mg #90 was denied on 10/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for diclofenac sodium 1.5 percent 60 grm # 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 124 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The CA MTUS/ODG states that Voltaren Gel 1% (diclofenac) is the only NSAID that is FDA approved for topical application, 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. In this case, there is no documentation of osteoarthritis and the indication for use is unclear. Furthermore, there is no documentation of any significant improvement in quantitative pain level (i.e. VAS) with prior use. Based on the cited guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

1 Prescription for tizanidine-zanaflex 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex Page(s): 66.

Decision rationale: According to the CA MTUS guidelines, Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. In this case, there is no evidence of spasticity, which is different from muscle spasm, in this IW. There is no documentation of trial of first line therapy or regular daily stretching exercise for the treatment of muscle spasm. Therefore, the request is not medically necessary.