

Case Number:	CM15-0013510		
Date Assigned:	02/02/2015	Date of Injury:	03/28/2008
Decision Date:	03/20/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/23/2015

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, Pain Management

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 year old female, who sustained an industrial injury on 3/28/2008. She has reported neck and bilateral upper extremity injuries as a baker. The diagnoses have included cervical and thoracic strain/sprain. Treatment to date has included medications, diagnostics, nerve block, and cervical radiofrequency. Currently, the injured worker complains of pain in the right shoulder and under right scapula. She saw a surgeon who felt that there was nothing to do for it at this time and a hand specialist who diagnosed her with arthritis of wrist and possible ganglion cyst. He felt conservative care was the best course at this time. She has benefitted from supraclavicular nerve blocks and cervical radiofrequency. She is unable to perform overhead activities and requires medications for pain. Physical exam revealed tenderness to palpation of right clavicle, stiffness and discomfort with extension and rotation, tenderness to palpation right shoulder/clavicle and difficulty reaching over head. Magnetic Resonance Imaging (MRI) of right upper extremity dated 1/21/14 revealed edema and cystic changes, possible bursal surface tear and ganglion cyst left wrist. She continues to work without restrictions and feels that without the medications and injections she would not be able to work. On 1/15/15 Utilization Review non-certified a request for Tizanidine 4mg quantity: 30 and Voltaren gel 1% 300gms quantity: 1, noting that regarding the Tizanidine 4mg medical necessity has not been established and regarding Voltaren gel 1% 300gms, the medical necessity for this topical agent has not been established. The (MTUS) Medical Treatment Utilization Schedule guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg quantity: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: Regarding the request for tizanidine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine is not medically necessary.

Voltaren gel 1% 300gms quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Regarding the request for Voltaren gel, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, the patient is noted to have some osteoarthritis of the wrist, but the CA MTUS does not support the long-term use of topical NSAIDs and there is no evidence of functional improvement from prior use. Given all of the above, the requested Voltaren gel is not medically necessary.