

Case Number:	CM15-0094420		
Date Assigned:	05/21/2015	Date of Injury:	09/22/1997
Decision Date:	06/22/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	05/18/2015

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: Massachusetts

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 54-year-old female who sustained an industrial injury on 9/22/97. The injured worker was diagnosed as having right carpal tunnel syndrome, right abductor pollicis longus and extensor pollicis brevis tenosynovitis, spinal stenosis lumbar spine without neurogenic claudication, rotator cuff capsule sprain/strain, superior glenoid labrum lesion, status post L4-S1 fusion, and partial thickness tear of the supraspinatus tendon. Currently, the injured worker was with complaints of discomfort in the left shoulder, right hand and lumbar spine. Previous treatments included medication management, activity modification, therapy and injections. Physical examination was notable for left shoulder with weak abduction against resistance and lumbar spine paraspinals tender to palpation. The plan of care was for medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac 75 mg Qty 60 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 68-73.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1997. She is being treated for left shoulder, right hand, and lumbar spine injuries. When seen, there was a positive left shoulder impingement testing. There was decreased and painful right wrist and hand range of motion. There was decreased lumbar spine range of motion with stiffness and paraspinal muscle tenderness. Medications were refilled. Oral NSAIDs (non-steroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain. Recommended dosing of diclofenac is up to 150 mg per day. In this case, the requested dosing is within guideline recommendations and therefore medically necessary.

Tizanidine 4 mg Qty 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-67.

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

Decision rationale: The claimant has a remote history of a work injury occurring in September 1997. She is being treated for left shoulder, right hand, and lumbar spine injuries. When seen, there was a positive left shoulder impingement testing. There was decreased and painful right wrist and hand range of motion. There was decreased lumbar spine range of motion with stiffness and paraspinal muscle tenderness. Medications were refilled. Tizanidine (Zanaflex) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for the management of spasticity and prescribed off-label when used for low back pain. In this case, there is no identified new injury or acute exacerbation and muscle relaxants have been prescribed on a long-term basis. The claimant does not have spasticity due to an upper motor neuron syndrome. It is therefore not medically necessary.