

Case Number:	CM13-0019205		
Date Assigned:	10/11/2013	Date of Injury:	05/20/2010
Decision Date:	07/30/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/03/2013

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 Clinical Psychology 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 57 year old male who sustained an injury on 05/20/10 while moving heavy objects. The injured worker sustained injury to the neck low back and left shoulder and elbow. Treatment to date included physical therapy and the injured worker also received epidural steroid injections for lumbar spine which provided temporary relief. The clinical record on 08/22/13 noted limited range of motion in the left shoulder on forward flexion and abduction. No motor weakness was identified. There were positive impingement signs with tenderness over the subacromial space and shoulder girdle. O'Brien signs were also positive. In the cervical spine there was paraspinal muscular tenderness. No neurological deficits were identified. In the lumbar spine there was intact range of motion with tenderness to palpation evident. Recommendations were for diagnostic arthroscopy regarding the left shoulder. No medications were specifically discussed at this visit. The requested Voltaren gel 1% 100g tube was not granted by utilization review on 08/26/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% 100g tube: Upheld

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

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

Decision rationale: In regards to the request for Voltaren Gel 1% 100g tube, this reviewer would not have recommended this request as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. Voltaren gel is a topical anti-inflammatory that can be considered as an option for the treatment of musculoskeletal complaints primarily due to osteoarthritis. The recommended use of Voltaren gel is for short term no more than 12 weeks. The clinical documentation submitted for review did not identify any side effects from the oral use of oral anti- inflammatories. No contraindications for oral anti-inflammatories were documented and it is unclear what the response of the injured worker has been to prior anti-inflammatories. Given the lack of any indications regarding contraindications or failure of standard oral anti-inflammatories, this reviewer would not have recommended this request as medically necessary. Therefore, the request is not medically necessary.