

Case Number:	CM13-0048547		
Date Assigned:	12/27/2013	Date of Injury:	01/06/2004
Decision Date:	03/20/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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 physician 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 patient is a 54-year-old female who reported an injury on 01/06/2004. The mechanism of injury is not specifically stated. The patient is currently diagnosed with torn rotator cuff tendon in the left shoulder, impingement syndrome in the left shoulder, bilateral carpal tunnel syndrome, severe left-sided TMJ dysfunction, and scapholunate disassociation. The patient was seen by [REDACTED] on 10/08/2013. The patient reported ongoing pain, stiffness, tenderness, and weakness. Physical examination revealed diminished strength, decreased cervical range of motion, decreased shoulder range of motion bilaterally, allodynia with swelling at the base of the 5th metacarpal, and intact sensation. Treatment recommendations included continuation of current medications, including amlodipine, fentanyl, glipizide, metformin, Norco, Omeprazole, Tramadol, and Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for Voltaren 1% gel #200 g: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical NSAID is diclofenac, which is indicated for osteoarthritis and tendinitis. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis or tendinitis. Additionally, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.