

Case Number:	CM13-0069027		
Date Assigned:	01/17/2014	Date of Injury:	10/25/2013
Decision Date:	05/30/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/20/2013

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 Occupational 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 patient has submitted a claim for right hand pain, with an industrial injury date of October 25, 2013. Treatment to date has included physical therapy and medications, which include Etodolac ER, Acetaminophen, and Polar Frost Gel. Medical records from 2013 were reviewed and revealed that the patient presents with continued wrist and hand pain, dull and aching in nature. Grip, grasp, lift, push, and pull exacerbate the pain while rest relieves the pain. There is burning sensation in the hands with numbness, tingling and weakness into the upper extremities with occasional difficulty with grip and grasp. On examination of bilateral wrists and hands, Tinel's test is positive in bilateral wrist. There is diminished sensation over digits 1, 2, and 3 in bilateral upper extremities. There is diminished grip strength in the right hand 5-/5.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (Diclofenac)..

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Voltaren Gel is 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, Voltaren Gel has been prescribed for right hand pain with the diagnostic impression of severe carpal tunnel syndrome of the right hand. The indication for this medication is not supported by the guidelines. Therefore, the requested Voltaren Gel is not medically necessary or appropriate.