

Case Number:	CM14-0005990		
Date Assigned:	03/03/2014	Date of Injury:	01/10/2005
Decision Date:	06/30/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/13/2014

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 Family Practice, 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 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 50 year old female who sustained an injury on 01/10/05. No specific mechanism of injury was noted. Rather this appeared to have been a cumulative trauma type injury. The patient was followed for complaints of both neck pain and low back pain as well as pain in the right wrist. Prior treatment included physical therapy and medications such as Naprosyn, Skelaxin, and Rozerem. Electrodiagnostic studies showed chronic right sided C7 radiculopathy. The patient also had epidural steroid injections. Recent medications included vicodin and Skelaxin. The clinical record from 01/14/14 was handwritten and somewhat difficult to interpret due to poor handwriting due to handwriting quality copy quality. Medications at this visit included vicodin and Skelaxin and Solaraze gel 3%. On physical examination there continued to be tenderness to palpation in the cervical spine. There appeared to be some possible atrophy in the left upper extremity. Diagnoses at this visit included medical epicondylitis and neck and low back pain. The patient was returned to full duty. Medications appeared to have been continued at this visit. The request for Solaraze gel 3% was non-certified by utilization review on 12/27/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOLARAZE GEL 3%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 112

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

Decision rationale: In regard to Solaraze gel 3%, this medication includes diclofenac which is an anti-inflammatory that was FDA approved for topical use in the treatment of osteoarthritic pain in the joints when there had been failure of oral anti-inflammatories or oral medications were not well tolerated or otherwise contraindicated. Specifically, Solaraze is FDA approved in the treatment of actinic keratosis. The clinical documentation submitted for review did not identify any objective findings consistent with this diagnosis. The clinical documentation also did not discuss any previous failure of anti-inflammatories or that the employee was unable to tolerate the use of oral anti-inflammatories. Given the limited findings supporting the use of Solaraze gel as outlined by FDA indications as well as current evidence based guidelines, this reviewer does not recommended this medication as medically necessary.