

Case Number:	CM14-0105827		
Date Assigned:	07/30/2014	Date of Injury:	06/07/2013
Decision Date:	08/29/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 44-year-old male who reported an injury on 06/07/2013 due to being hit by a motor vehicle that was backing up. Diagnoses were strain, lumbar spine, hip pain, and right labrum tear. Past treatments were epidural steroid injection, physical therapy, and aqua therapy. Diagnostic studies were an MRI of the lumbar spine on 08/13/2013. No surgical history was reported. The injured worker had a physical examination on 07/09/2014 with complaints of right hip pain. The injured worker reported the pain level was a 7/10. He also stated it affected many activities of daily living. Examination revealed 50% improvement overall. Hip range of motion was reduced 50%. There was a positive load test. There was a positive left FABER test and load test. Deep tendon reflexes were right patellar 2/4, Achilles 2/4, left patellar 2/4, and Achilles 2/4. Medications were omeprazole, ibuprofen, and Voltaren gel 1%. Treatment plan was for arthroscopy surgery for labral repair with a femoral neck resection, acetabular takedown, trochanteric bursectomy, and possible abduction repair. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%: 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 Topical Analgesics Page(s): 111, 112.

Decision rationale: The request for Voltaren gel 1% is non-certified. The California Medical Treatment Utilization Schedule states 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 guidelines also state that for Voltaren 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrists). It has not been evaluated for the treatment of the spine, hip, or shoulder. Voltaren contains a nonsteroidal anti-inflammatory drug diclofenac. This medication is indicated for the use of osteoarthritis. It is not to be used on the spine, hips, or shoulders. The injured worker does not have a diagnosis of osteoarthritis. The request submitted does not indicate the frequency or the quantity. Therefore, the request is non-certified.