

Case Number:	CM14-0012869		
Date Assigned:	02/24/2014	Date of Injury:	05/07/2007
Decision Date:	09/24/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/31/2014

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 64 year old female with a reported date of injury on 05/07/2007. The mechanism of injury was repetitive stress. The diagnoses included neck pain and carpal tunnel syndrome. The past treatments were pain medication and chiropractic therapy. The MRI to the lumbar spine done on 05/05/2009 revealed degenerative disc disease at L3-4 and L5-S1 levels. On 01/16/2014, the subjective complaints were neck and shoulder pain. The physical examination noted increased pain with flexion and extension at the right cervical spine. The medications were Naproxen, Voltaren gel, Lidocaine ointment, Capsaicin cream, and Ketamine cream. The treatment plan was to continue medications. The rational was to decrease pain. The request for authorization form is dated 01/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REVIEW FOR VOLTAREN 1% GEL TO PAINFUL AREA THREE TIMES DAILY FOR LOW BACK AND UPPER EXTREMITY PAIN #1 WITH THREE REFILLS (RX DR. MORLEY 12/19/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The request for retrospective review for voltaren 1% gel to painful area three times daily for low back and upper extremity pain #1 with three refills (rx [REDACTED] 12/19/13) is not medically necessary. The California MTUS guidelines state that Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment; however, it has not been evaluated for treatment of the spine, hip or shoulder. The injured worker presents with neck and shoulder pain and use of Voltaren gel is not supported in the spine, hip or shoulder. Since Voltaren is not indicated for use in the spine or shoulder the request is not supported. Additionally, the request, as submitted, did not specify a quantity. As such, the request is not medically necessary.