

Case Number:	CM14-0133184		
Date Assigned:	08/25/2014	Date of Injury:	02/11/2008
Decision Date:	09/24/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/20/2014

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 Pain 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 injured worker is a 64-year-old male, who reported injury after he tripped and fell 02/11/2008. The clinical note dated 06/19/2014 indicated diagnoses of shoulder pain, spasm of muscle, and cervical strain. The injured worker reported neck pain and left shoulder pain. The injured worker rated his pain a 2/10 with medication, without medication a 3/10. The injured worker reported his quality of sleep was good. The level had remained the same. On physical examination cervical spine range of motion was restricted. The examination of the shoulder range of motion was restricted with flexion and abduction. The injured worker's treatment plan included followup in 4 weeks. The injured worker reported his medications worked well to decrease his pain to a tolerable level so that he can do daily activities. The injured worker reported he used the Celebrex and Voltaren Gel separately. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Celebrex and Voltaren Gel. The provider submitted a request for Celebrex and Voltaren Gel. A Request for Authorization was not submitted for review, to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 capsules of Celebrex 200mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The request for 60 capsules of Celebrex 200mg is not medically necessary. The CA MTUS guidelines recognize anti-inflammatories as the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Although the injured worker reports efficacy with the use of Celebrex, it is not indicated how long the injured worker had been utilizing the Celebrex. In addition, the request does not indicate a frequency for the Celebrex. Therefore, the request for Celebrex is not medically necessary.

One tube of Voltaren gel 1%: Upheld

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

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

Decision rationale: The request for One tube of Voltaren gel 1% is not recommended. The California MTUS guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The California Chronic Pain Medical Treatment Guidelines states Voltaren Gel 1% (diclofenac): 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. Voltaren Gel is indicated for relief of osteoarthritis and pain in his joints. However, it has not been evaluated for treatment of the spine, hip, or shoulder. In addition, the request does not indicate a frequency for the Voltaren Gel. Moreover, it is not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. Additionally, it was not indicated how long the injured worker had been utilizing the Voltaren Gel. Therefore, the request for Voltaren Gel is not medically necessary.