

Case Number:	CM14-0150103		
Date Assigned:	09/18/2014	Date of Injury:	03/30/2012
Decision Date:	10/17/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/15/2014

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 Internal Medicine, has a subspecialty in Nephrology 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:

This is a 50-year-old female with a 3/30/12 date of injury. A specific mechanism of injury was not described. According to a progress report dated 7/24/14, the patient had recently had physical therapy for a neck injury and left upper extremity. She rated her current pain level of 7/10. She has not done any vigorous activities to avoid "flaring things up". Objective findings: tenderness at the right medial and lateral epicondyle and cubital tunnel and right upper back and neck, decreased sensation in the 4th and 5th fingers. Diagnostic impression: right upper extremity repetitive straining injury with right medial epicondylitis, right ulnar and radial neuritis, right lateral epicondylitis, and right wrist tendinitis. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 8/19/14 denied the request for Voltaren gel. There is no indication of failed trials of oral NSAID therapy, as well as evidence of objective functional benefit with prior use of this topical medication. There is also no indication of osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel times (x) six (6) refills: Upheld

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

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

Decision rationale: CA MTUS states 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); and has not been evaluated for treatment of the spine, hip or shoulder. There is no documentation that the patient has pain of an arthritic component. In addition, there is no documentation that the patient is unable to tolerate oral medications, or has had a trial and failure of oral NSAIDs. Therefore, the request for Voltaren gel times (x) six (6) refills was not medically necessary.