

Case Number:	CM14-0024921		
Date Assigned:	06/11/2014	Date of Injury:	04/11/2011
Decision Date:	07/15/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/27/2014

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 American Board of Orthopaedic Surgery 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 59-year-old female who was reportedly injured on 4/21/2011. The mechanism of injury was noted as a motor vehicle accident. The most recent progress note dated 1/14/2014 indicated there were ongoing complaints of neck pain with upper extremity pain, numbness, tingling and weakness. Physical examination demonstrated an alert, oriented female without signs of sedation, continued tactile allodynia over forearms, grip decreased and fatigue with continued contraction of upper, forearm and grip, decreased sensation over triceps (right greater left). MRI of the cervical spine, dated 12/11/2013, showed the presence of a syrinx in the cervical spine that was not present in a previous study. Diagnoses: Cervical syrinx with myelopathy, upper extremity neuropathic pain, cervical radiculopathy and stenosis. Previous treatment included a cervical injection, physical therapy, traction, Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy and medications to include: Cymbalta, Neurontin, Percocet and ibuprofen. A request had been made for Voltaren cream 100 gm #4 tubes and was certified/modified for Voltaren cream #4 tubes with no refills in the pre-authorization process on 1/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN CREAM 100GM #4 TUBES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Voltaren Gel.

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

Decision rationale: Voltaren gel/cream is a topical NSAID indicated for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Outside of the treatment of osteoarthritis, there is no other clinical indication for the use of this medication. Given the current MTUS guidelines, this request is not considered medically necessary.