

Case Number:	CM14-0031791		
Date Assigned:	04/09/2014	Date of Injury:	08/21/2010
Decision Date:	05/08/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/05/2014

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, Pulmonary Diseases 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 47-year-old male who reported an injury on 08/21/2010. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his left wrist, low back with bilateral lower extremity pain, and bilateral foot pain. The injured worker's treatment history included physical therapy, activity modifications, a Transcutaneous Electrical Nerve Stimulation (TENS) unit, acupuncture, chiropractic treatment, a lumbar brace, and multiple medications. The injured worker was evaluated on 10/17/2013. It was documented that the injured worker had ongoing pain complaints to multiple body parts. Medications did provide an appreciable degree of relief. The injured worker's medication schedule included Medrox ointment, Norco 10/325 mg, omeprazole, etodolac, Lidoderm 5% patches, Voltaren 1% gel, and Cymbalta 60 mg. Physical findings included globally reduced range of motion secondary to pain, reduced motor strength in the hip flexors, and a positive straight leg raising test bilaterally. The injured worker's diagnoses included closed fracture of unspecified vertebrae without spinal cord injury, thoracic or lumbosacral neuritis or radiculitis, myalgia and myositis, osteoarthritis, depressive disorder, sleep disturbance, long term medication usage. The injured worker's treatment plan included continuation of medications, continuation of physical therapy and acupuncture, and selective nerve root blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN 1% GEL WITH 3 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 Topical Analgesics Page(s): 111.

Decision rationale: The requested Voltaren 1% gel with 3 refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends topical nonsteroidal anti-inflammatory drugs for injured workers who cannot tolerate oral medications or if oral medications are contraindicated for the injured worker. The clinical documentation submitted for review does indicate that the injured worker has gastritis related to medication usage. However, California Medical Treatment Utilization Schedule does not support the long term use of nonsteroidal anti-inflammatory drugs as topical analgesics. The clinical documentation submitted for review does indicate that the injured worker has been using this medication since at least 05/2011. This exceeds guideline recommendations of 2 to 4 weeks. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the requested Voltaren 1% with 3 refills does not include a frequency or duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Voltaren 1% gel with 3 refills is not medically necessary or appropriate.