

Case Number:	CM14-0051232		
Date Assigned:	07/07/2014	Date of Injury:	07/25/2011
Decision Date:	08/28/2014	UR Denial Date:	04/07/2014
Priority:	Standard	Application Received:	04/18/2014

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 Occupational 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 patient is a 44-year-old female who has submitted a claim for myofascial sprain and strain of the cervical spine, possible degenerative disc disease of the cervical spine, bursitis of the left shoulder, and cervical radiculopathy associated with an industrial injury date of July 25 2011. Medical records from 2013-2014 were reviewed. The patient complained of neck and left shoulder pain, rated 5-8/10 in severity. The pain radiates to the left upper extremity. Physical examination showed tenderness in the cervical spine and paraspinal muscle, more on the left than the right. There was painful range of motion of the cervical spine. Tenderness was also noted on the left shoulder anteriorly and posteriorly with painful range of motion. Neurological examination showed radicular pain on C5-C6 and C6-C7 distribution. The MRI of the cervical spine dated March 24, 2009 revealed mild disc bulges at multiple levels. MRI of the left elbow dated September 12, 2013 showed mild ulnar neuritis along with a small elbow effusion. Treatment to date has included medications, acupuncture, home exercise program, TENS unit, and activity modification. Utilization review, dated April 7, 2014 denied the request for Voltaren Gel 1% 100gm tube, qty. 1, refill: 3. Reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 100mg # 1, refills: 3: 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): 112.

Decision rationale: According to page 112 of the California MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, the patient was prescribed Voltaren gel in September 2013. Voltaren was prescribed in conjunction with oral pain medications. However, the use of Voltaren is not in accordance with guideline recommendations as there is little evidence for its use for neck and shoulder pain. The medical records also failed to provide evidence of osteoarthritis, which may warrant the use of Voltaren gel. The medical necessity was not established. Therefore, the request for Voltaren Gel 1% 100mg # 1, refills: 3 is not medically necessary.