

<b>Case Number:</b>	CM14-0053097		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	02/01/2010
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 is licensed to practice in Illinois. 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 49-year-old female who reported an injury on 02/01/2010 reportedly, while working for [REDACTED] she did computer research and injured her right elbow and right arm. The injured worker's treatment history included medication, injections, EMG/NCV, x-ray, and physical therapy. The injured worker was evaluated on 09/25/2013 and it was documented that the injured worker complained of persistent upper extremity pain. On the physical examination, the injured worker's right upper extremity showed tenderness about the lateral epicondyle on the right side. The radial tunnel was tender. There was evidence of allodynia. She could extend to 0 degrees and flex to 100 degrees. The injured worker was evaluated on 02/25/2014, and it was documented that the injured worker complained of persistent aching pain in her right elbow with numbness in her right hand and wrist. Symptoms were aggravated with forceful gripping and cold weather. The provider noted that an ergonomic workstation evaluation would be in the injured worker's best interest. It was noted that an extracorporeal shockwave therapy was authorized. Diagnoses included right elbow posttraumatic lateral epicondylitis, radial tunnel syndrome with resultant complex regional pain syndrome and insomnia - compensatory. Medications included Salonpas pads and Voltaren cream. The request for authorization rationale was not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Salonpas pads #30:** 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 Page(s): 111.

**Decision rationale:** The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. The guidelines state that there are no other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. The documentation submitted failed to indicate the injured worker's conservative care measures such as, physical therapy and pain medicine management outcome. In addition, request did not provide frequency or location where the patches will be applied. As such, the request for Salonpas pads #30 is not medically necessary.

**Voltaren cream 10gm tid:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal antiinflammatory agents).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Voltaren Gel 1 %, page(s) 112 Page(s): 112.

**Decision rationale:** The request is not medically necessary. The California MTUS Guidelines state that Voltaren Gel 1% (Diclofenac) is recommended 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. The documents submitted lacked outcome measurements of medication management and home exercise regimen. In addition, the request lacked frequency, duration and location where the medication is supposed to be applied for the injured worker. Given the above, the request for Voltaren cream 10gm is not medically necessary.