

Case Number:	CM14-0062881		
Date Assigned:	07/11/2014	Date of Injury:	12/24/2010
Decision Date:	09/17/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	05/05/2014

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 Physical Medicine and Rehabilitation 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 60-year-old female who reported an injury on 12/23/2010. The mechanism of injury was not provided for clinical review. The diagnoses include left shoulder pain, left rotator cuff tear, status post diagnostic arthroscopy and cuff debridement, left groin pain, left hip degenerative joint disease, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, lumbar discogenic pain syndrome. Previous treatments included medication, epidural steroid injections and MRI. Within the clinical note dated 02/21/2014, it was reported the injured worker complained of low back pain which radiated to the left thigh. She complained of cramping of the left leg. Upon the physical examination, the provider noted active range of motion of the left shoulder with flexion at zero to 90 degrees. Reflexes were 2+ for both quadriceps and gastrocnemius. The provider noted the injured worker complained of multiple areas of pain. The provider requested Voltaren gel. However, a rationale was not provided for clinical review. The request for authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% QTY: 30 with 300 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 NSAIDs Page(s): 111-112.

Decision rationale: The request for Voltaren gel 1%, quantity 30, with 300 refills is not medically necessary. The California MTUS Guidelines note topical NSAIDS are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDS are recommended for short term use of 4-12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The injured worker had been utilizing the medication since at least 01/2014, which exceeds the guidelines recommendation of short term use. Therefore, this request is not medically necessary.