

<b>Case Number:</b>	CM14-0070218		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	03/31/2011
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 was a 50-year-old female who reported an injury on 03/31/2011 after some boxes fell and hit her in the face and head. The injured worker had a history of chronic lock jaw. The diagnoses included psychogenic headaches, tension type headache, carpal tunnel syndrome, pain to the eye, derangement of the temporomandibular joint, shoulder joint pain, left wrist pain, medical epicondylitis, lateral epicondylitis, myofascial pain, and dislocation of the temporomandibular joint. The past treatments included a bilateral upper extremity electromyography for cervical myofascial pain, no results provided. The past surgical history included bilateral carpal tunnel release, bilateral knee surgery, left shoulder surgery times 2, and rhinoplasty dated 05/2011 for fractures nasal septum. The objective findings dated 06/20/2014 revealed range of motion with in normal limits, pain noted upon lateral excursions, however, lateral movements were bilaterally symmetric and within normal limits. Slight tenderness to palpation at the left lateral chondral with a deviation upon opening. The medication included Colace 100 mg, gabapentin 300 mg, Norco 10/325 mg, Voltaren 1% topical gel, and Xanax 2 mg. No VAS provided. The Request for Authorization for the CT dated 04/17/2014 was submitted with documentation. The rationale for the CT and Voltaren gel was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Head CT Scan:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Head CT (Computed tomography).

**Decision rationale:** The request for head CT scan is not medically necessary. The Official Disability Guidelines indicate that CT scans are recommended for abnormal mental status, focal neurologic deficits, or acute seizure and should also be considered in the following situations. Signs of basilar skull fracture, Physical evidence of trauma above the clavicles acute traumatic seizure Age greater than 60, an interval of disturbed consciousness Pre-or post-event amnesia Drug or alcohol intoxication or any recent history of TBI, including MTBI. Per the clinical note provided, the injured worker had a nasal fracture that was repaired in 2011. The injured worker's injury was in 2011. Not evident of any new reports of recent injury. No evidence of amnesia, drug or alcohol intoxication. As such, the request is not medically necessary.

**Voltaren 1% Gel:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 111-112.

**Decision rationale:** The request for Voltaren Gel, 04/02/2014 is not medically necessary. The California MTUS states Voltaren Gel 1% (Diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The California MTUS Guidelines indicate that Voltaren gel is not indicated for the ankle, elbow, foot, hand, knee, or wrist and has not been evaluated for the treatment of the spine, hip, or shoulder. The documentation did not address the measurable functional deficits or the injured worker's pain or location of the pain. The frequency was not address. As such, the request is not medically necessary.