

Case Number:	CM14-0200436		
Date Assigned:	12/10/2014	Date of Injury:	12/01/1998
Decision Date:	01/27/2015	UR Denial Date:	11/15/2014
Priority:	Standard	Application Received:	12/01/2014

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:

This is a 52-year-old female with a 12/1/98 date of injury. According to a progress report dated 9/4/14, the patient complained of neck pain, bilateral wrist pain, and left foot pain. She rated her pain with medications as a 5/10 and without medications as a 7/10. She had no new problems or side effects. Her activity level has increased and that her medications were working well. Objective findings: restricted range of motion of cervical spine, spasm/tenderness/tight muscle band and trigger band noted on right side of cervical paravertebral muscles, tenderness noted at the trapezius and right cervical facet joints, tenderness noted on both sides of lumbar paravertebral muscles, light touch sensation normal, motor testing limited by pain. Diagnostic impression: low back pain, cervical facet syndrome, radiculopathy, cervical pain, pain in limb, wrist pain. Treatment to date: medication management, activity modification. A UR decision dated 11/15/14 denied the request for Voltaren gel. There is no documentation that this patient has osteoarthritis, therefore, this is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel with three refills, apply to affected body part 2-3 times per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. However, in the present case, there is no documentation that this patient has a diagnosis or symptoms of osteoarthritis. In addition, there is no documentation that she is unable to tolerate oral medications. Therefore, the request for Voltaren 1% gel with three refills is not medically necessary.