

Case Number:	CM14-0204914		
Date Assigned:	12/17/2014	Date of Injury:	01/27/2012
Decision Date:	02/11/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	12/08/2014

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 Rehab 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 55 year old male with date of injury 1/27/12. The treating physician report dated 10/13/14 (228) indicates the patient presents with chest pain and shortness of breath. The physical examination findings reveal the chest was clear and chest wall was tender to palpation over the sternum and the xipoid process. Patient underwent Spirometric Lung Function Testing, which revealed mildly reduced FVS indicative of mild restrictive ventilatory defect. Chest x-rays were performed 05/01/14, which shows sub segmental atelectasis vs. scarring in the left lung base. Suggestions of hiatal hernia. Also on May 1st, pulmonary function testing was done that revealed, "mild restrictive lung disease, there was no improvement following administration of aerosolized bronchodilator. Single breath diffusion mildly reduced. Lung volumes are consistent with restrictive lung disease. Air resistance and conductance consistent with obstructive lung disease." The current diagnosis is: 1. Chest wall pain, probably secondary to Tietze syndrome The utilization review report dated 11/06/14 denied the request for Voltaren based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 5% gel, 100 gram tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The patient has chest pain and shortness of breath. The current request is for Voltaren 5% gel, 100 gram tube. The treating physician indicates that the request is for "topical use on the chest" (page 233). The MTUS Guidelines are specific that topical NSAIDS are for, "Indicated 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 MTUS does not specify about the chest area but it is specific on the way it is to be used. It is specific that it is only to be used for osteoarthritis pain in specific areas. The current request does not fit into those requirements as outlined in the MTUS guidelines. This request is not medically necessary.