

Case Number:	CM15-0167515		
Date Assigned:	09/08/2015	Date of Injury:	05/19/2015
Decision Date:	10/09/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/25/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 23 year old male, who sustained an industrial-work injury on 5/19/15. He reported initial complaints of having pain with acute rib and scapula fracture. The injured worker was diagnosed as having right scapula fracture, right multiple rib fractures, traumatic pneumothorax, and lumbar vertebral fracture. Treatment to date has included medication, diagnostics, and surgery (ORIF - open reduction internal fixation). Currently, the injured worker complains of left wrist, rib cage, right shoulder, and mid back pain. Per the primary physician's progress report (PR-2) on 7-24-15, exam notes tenderness to palpation in all parts (spine, ribs, right shoulder), decreased range of motion, and neurologically intact. The requested treatments include Voltaren gel 100 gm and TENS (transcutaneous electrical nerve stimulation) unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 100 g, 1 tube with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents on 07/24/15 with pain in the left wrist, rib cage and right shoulder. The patient's date of injury is 05/19/15. Patient is status post screw fixation of a left scaphoid fracture on 07/16/15. The request is for Voltaren gel 100g, 1 tube with 1 refill. The RFA is dated 07/27/15. Physical examination dated 07/24/15 reveals tenderness to palpation of the T8-12 paraspinal muscles and ribs, and tenderness of the right AC joint and acromion. The progress note is handwritten and unclear in some portions. The patient is currently prescribed Norco. Patient's current work status is not provided. MTUS Guidelines, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." "This class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (Diclofenac): 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." In regard to Voltaren gel for this patient's ongoing pain, the requesting provider has not specified where it is to be applied. This patient presents following traumatic injury to the ribs, right shoulder, and left wrist. Guidelines do not support the use of topical NSAIDs such as Voltaren gel for spine, hip, or shoulder pain; as they are only supported for peripheral joint arthritis and tendinitis. While this patient presents with complaints in the left wrist, the provider does not specify that this gel is intended for use on this particular injury. Without evidence that this medication is being utilized for a peripheral complaint, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.

TENS (transcutaneous electrical nerve stimulation) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents on 07/24/15 with pain in the left wrist, rib cage and right shoulder. The patient's date of injury is 05/19/15. Patient is status post screw fixation of a left scaphoid fracture on 07/16/15. The request is for TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) UNIT. The RFA is dated 08/05/15. Physical examination dated 07/24/15 reveals tenderness to palpation of the T8-12 paraspinal muscles and ribs, and tenderness of the right AC joint and acromion. The progress note is handwritten and unclear in some portions. The patient is currently prescribed Norco. Patient's current work status is not provided. MTUS Guidelines, Transcutaneous electrotherapy section, page 114-116, under Criteria for the use of TENS states: "A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function." In this case, the provider is requesting a TENS unit for this patient's continuing right shoulder, rib, and left wrist pain. However, there is no documentation of an intent to perform a 30-day trial prior to purchase. Progress note dated 08/05/15 does note that in-office application of the unit was effective at reducing this patient's pain, though does not discuss previously successful 30 day trials or an intent to perform one. Were the request for a 30 day trial of the unit, the recommendation would be for approval. As there is no evidence of a successful 30 day trial performed previously, the request as written cannot be substantiated.

Therefore, the request IS NOT medically necessary.