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| Case Number: | CM15-0191795 | | |
| Date Assigned: | 10/05/2015 | Date of Injury: | 08/26/2011 |
| Decision Date: | 11/12/2015 | UR Denial Date: | 09/22/2015 |
| Priority: | Standard | Application Received: | 09/29/2015 |

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 40 year old male, who sustained an industrial injury on 8-26-11. The documentation on 8-28-15 noted that the injured worker has complaints of multiple pain areas. The injured worker had a really bad flare-up last month. The documentation noted for objective findings the injured worker is continuing on his wheelchair and he is in mild to moderate distress. The diagnoses have included reflex sympathetic dystrophy of the upper limb. Treatment to date has included right hip surgery in November 2011; Functional Restoration Program and Hospital Elder Life Program (HELP) program. The injured workers current medications Klonopin; Compazine; metoprolol; lisinopril; nortriptyline; soma; gabapentin; Restoril; pantoprazole; topamax; Colace; MiraLax powder; Proctosol-HC cream; hydrocortisone and hydrocortisone. Computerized tomography (CT) scan of the pelvis on 11-22-11 showed no acute fractures. Magnetic resonance imaging (MRI) of the right pelvis, thigh on 2-13-12 showed postoperative changes. Magnetic resonance imaging (MRI) of the thoracic and lumbar spine on 11-2-12 showed minimal degenerative changes without central or foraminal stenosis. The original utilization review (9-22-15) non-certified the request for voltaren gel #5 with one (1) refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel #5 with one (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 MTUS lists Voltaren Gel as an FDA approved medication 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, and there no formal guidance encouraging its use in neuropathic pain. The patient has been treated with topical Voltaren and with no evidence of functional improvement coupled with the lack of evidence for use in the surface regions and neuropathic nature of this patient's complaints, the request cannot be considered medically necessary.