

Case Number:	CM15-0031340		
Date Assigned:	02/24/2015	Date of Injury:	11/30/2011
Decision Date:	04/03/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	02/19/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 54 year old right handed female, who sustained a work/ industrial injury on 11/30/11 due to cumulative trauma. She has reported symptoms of cramping pain in right wrist, elbow, and forearm. Prior medical history was not documented. The diagnoses have included right medial epicondylitis, right wrist tendinitis, right forearm extensor tendinitis, right upper extremity repetitive injury. Treatments to date included diagnostics, 6 sessions of acupuncture, steroid injection for right carpal tunnel syndrome, occupational therapy x 12 sessions, Transcutaneous Electrical Nerve Stimulation (TENS) unit, and 10 physical therapy sessions. Diagnostics included Magnetic Resonance Imaging (MRI) noted early degenerative change of the first carpometacarpal articulation, mild extensor carpi ulnaris tendinopathy, and 2 ganglia over the volar aspect of the radial styloid. Medications included Voltaren gel. The treating physician's report (PR-2) from 1/14/15 indicated tenderness to right wrist, elbow, forearm; tenderness to right medial epicondyle; muscle strength of 5/5; negative Hoffman's testing; and intact sensation. Treatment plan was for home paraffin bath and ergonomic evaluation, modified work and Voltaren gel. On 2/9/15, Utilization Review non-certified Voltaren 1% gel as directed #3-100g tubes with 1 refill, noting the California Medical treatment Utilization Schedule (MTUS) Guidelines. On 2/9/15, Utilization Review non-certified a Home Paraffin wax unit, noting the Non-Medical treatment Utilization Schedule (MTUS) Official Disability Guidelines (ODG) Wrist, Hand; Paraffin wax baths.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Paraffin wax unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist, Hand; Paraffin wax baths.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand, wrist, forearm/ paraffin.

Decision rationale: ODG states; "Recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). According to a Cochrane review, paraffin wax baths combined with exercises can be recommended for beneficial short-term effects for arthritic hands." The provided medical record does not indicate that this treatment was intended for use to treat arthritis, in fact there is no diagnosis of arthritis listed for this IW. The treatment seems to be intended for relief of tendinitis/tendinopathy, disorders for which it is not indicated per the ODG. As such the request for a home paraffin wax unit is deemed not medically necessary.

Voltaren 1% gel as directed #3-100g tubes with 1 refill: Upheld

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

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

Decision rationale: MTUS specifically states for Voltaren gel (diclofenac); that it is "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." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment would be for tendinitis/tendinopathy, disorders for which it is not indicated. As such the request for Voltaren gel 1% is deemed not medically necessary.