

Case Number:	CM15-0087001		
Date Assigned:	05/11/2015	Date of Injury:	09/30/2011
Decision Date:	06/15/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/06/2015

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 injury on 9/30/11. He has reported initial complaints of falling through a roof at 35-40 feet with loss of consciousness of uncertain duration. The diagnoses have included status post fall post-concussion syndrome, status post brain hemorrhage/traumatic brain injury, status post bilateral pneumothoraces, status post comminuted fracture of the right iliac crest, post-operative exploratory Laparotomy, post-operative closed operative manipulation of right iliac crest fracture, chronic right pelvic and hip pain, chronic bilateral shoulder pain, diffuse spinal pain and depression. Treatment to date has included medications, activity restrictions, diagnostics, surgery, transcutaneous electrical nerve stimulation (TENS), physical therapy, and activity modifications. Currently, as per the physician progress note dated 4/2/15, the injured worker complains of right hip pain rated 8/10 at night at night and unable to sleep. He states that the pain goes down to 2/10 on pain scale with use of transcutaneous electrical nerve stimulation (TENS) unit. He reports that he is able to tolerate working with use of oral pain medications. He state that he takes one Percocet when he gets home from work and tried to take half of a tab at night but wakes at night with aches and pains. Physical exam revealed gait with right antalgia, slight wasting of the quadriceps and gastro on the right leg, hyporeflexic lower extremities and positive Trendelenburg test on the right. The current medications included Percocet, Topiramate and Voltaren gel. Work status is modified with restrictions as of 4/2/15. The physician requested treatment included Voltaren Gel 1% quantity 200mg with three refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% quantity 200mg with three refills: Upheld

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

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

Decision rationale: The patient presents on 04/02/15 with right hip pain rated 8/10 and loss of sleep secondary to pain. The patient's date of injury is 09/30/11. Patient is status post close operative manipulation of right iliac crest fracture and exploratory laprotomy following traumatic fall injury. The request is for NON-CERTIFY: VOLTAREN GEL 1% THREE TIMES PER DAY 200MG, 3 REFILLS (PRESCRIBED 04/02/15). The RFA was not provided. Physical examination dated 04/02/15 reveals an antalgic gait especially on the right side, muscle atrophy of the quadriceps and gastrocnemius muscles on the right, reduced reflexes in the bilateral lower extremities, and positive Trendelenburg test on the right. The patient is currently prescribed Voltaren gel, Percocet, and Topiramate. Diagnostic imaging was not provided. Patient is currently working with modified duties. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): 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. 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 the continuation of Voltaren gel for this patient's chronic hip pain, this medication is not supported for this patient's chief complaint. The requesting provider documents chronic pain in the hip region, but does not specifically state where the Voltaren is to be applied. 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. Without a clearer indication as to where this medication is to be applied, or evidence of the presence of peripheral joint complaints amenable to topical NSAIDs, use of this medication cannot be substantiated. Therefore, the request IS NOT medically necessary.