MAXIMUS Federal Services

Case Number:	CM13-0004800		
Date Assigned:	01/15/2014	Date of Injury:	05/15/2007
Decision Date:	03/19/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	07/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 physician 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 64-year-old female with date of injury of 05/15/2007. The listed diagnoses per [redacted] dated 07/01/2013 are : 1. Reflex sympathetic dystrophy of the upper limb 2. Status post extensive left upper extremity and wrist surgery, date unknown. According to progress report dated 07/01/2013 by [redacted], the patient is status post extensive left upper extremity and wrist surgery. The patient complains of pain symptoms in her right upper extremity. She describes her pain as stabbing without tingling or numbness. The patient states that the TENS unit is an essential part of her pain management and is allowing her to be more functional during the day. The patient also notes that the use of the TENS unit improves her sleep. Objective findings show that the patient is well-developed, well-nourished, and is on no cardio respiratory distress. The patient ambulates to the examination room without assistance. She is able to sit comfortably without difficulty or evidence of pain. The treater is requesting a refill for Voltaren gel 1% to be applied to affected areas up to 4 times a day with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% apply 2 grams to affected area up to 4x a day #2: Upheld

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

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

Decision rationale: The patient presents with upper extremity pain. The treater is requesting a refill for Voltaren gel 1% to be applied to affected areas. Utilization report dated 07/11/2013, denied the request because there was no documentation of osteoarthritis pain in joints that lend themselves to topical treatments and failure of an oral NSAID or contraindications to oral NSAID. MTUS for topical creams page 111 for chronic pain states that topical analgesics are largely experimental. Voltaren is an FDA approved agent indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatments (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. In this case, the patient has chronic upper extremity pain specifically localized in the shoulder and forearm area. Review of documents from 02/25/2013 to 11/25/2013, did not show diagnoses of peripheral joint osteoarthritis. Given that the patient has no documented osteoarthritis or tendinitis, recommendation is for denial.