

Case Number:	CM14-0146527		
Date Assigned:	09/12/2014	Date of Injury:	09/28/2009
Decision Date:	10/14/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/09/2014

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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in Texas. 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/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 injured worker is a 58-year-old female with a reported injury on 09/28/2009. The mechanism of injury was that she was run over by a forklift wheel. The injured worker's diagnoses included cervical syndrome with radiculopathy, left elbow sprain/abrasion, lumbosacral syndrome with sciatica, right and left knee pain, status post bimalleolar fracture, left ankle/status post-surgery and plantar fasciitis. The injured worker's previous treatments included medications, rest, immobilization, physical therapy, and a transforaminal nerve block on 03/30/2012 at the level of L4, L5, and S1. The injured worker's previous diagnostic testing included x-rays of cervical and lumbosacral spine on 06/01/2012, an MRI of the lumbar spine dated 01/23/2012, an electrodiagnostic study dated 01/18/2011, and a CT scan dated 10/29/2012. The injured worker's surgical history included an open reduction and internal fixation of the left ankle on 10/05/2009 and a posterior capsulotomy of the left ankle with Achilles lengthening and removal of hardware (syndesmotic screws x 2) on 06/02/2010. The injured worker was evaluated for left foot pain on 08/06/2014. The clinician observed and reported a focused physical examination. The left ankle was noted to be painful with motion. The left foot was swollen on the lateral aspect. Tenderness to palpation was noted at the calcaneal tuberosity and of the left heel medially, and the medial tarsometatarsal joints. Vibration hyperesthesia was noted to the left foot medial plantar arch. The injured worker's medications included Voltaren gel 1%. The request was for Voltaren gel x 1. No rationale for the request was provided. The Request for Authorization form was provided but undated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs).

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

Decision rationale: The injured worker complained of left foot pain. The California MTUS Chronic Pain Medical Treatment Guidelines recommend Voltaren gel 1% for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, including the ankle, elbow, foot, hand, knee, and wrist. The injured worker does not have a diagnosis of arthritis. Additionally, the request did not include a frequency of dosing, a site of application, or a dosage amount. Therefore, the request for Voltaren gel x 1 is not medically necessary.