

Case Number:	CM14-0150263		
Date Assigned:	09/18/2014	Date of Injury:	09/16/2008
Decision Date:	10/17/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 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:

This is the case of a 64 year old female, with a date of injury 9/16/2008, due to an undisclosed mechanism of injury. The patient came in for a follow-up due to left upper extremity pain. She has osteoarthritis of the first metacarpal phalangeal joint, has undergone 2 surgeries and has compensatory muscle pain in the left upper extremity. Subjectively, no difference noted in the pain sensation felt. Pain is constant and is located around the CMC joint. Also observes numbness and tingling from the left 2nd finger up to her forearm, radiating towards the neck. There is an increase in the weakness of her left wrist, hand and arm. Poor grip noted as well. There is also an observed decrease in the range of motion. Temporary and adequate relief is noted upon intake of her medications. On physical examination, normal muscle tone without atrophy, with 5/5 muscle strength on right upper extremity noted, and 3-4/5 on the left upper extremity. No edema or direct tenderness noted on palpation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium 1.5% 60 gm #1: 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: Medical necessity for this request has not been established. MTUS Chronic Pain Medical Treatment Guidelines identify that 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). The guidelines do support a 1% Diclofenac formulation for arthritis however; the medical documentation does not describe any x-rays showed arthritis. It is not entirely clear where the patient uses the cream or whether there is any intolerance to oral anti-inflammatories. For the reasons above, the request is not medically necessary.