

Case Number:	CM14-0160136		
Date Assigned:	10/03/2014	Date of Injury:	11/10/2011
Decision Date:	11/06/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/30/2014

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 & Rehabilitation 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:

The injured worker is a 42-year-old female who reported an injury on 11/10/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included right shoulder calcification tendinitis with subacromial impingement, right moderate carpal tunnel syndrome, right cubital tunnel syndrome, right foot chronic sprain. The previous treatments included medication. Within the clinical note dated 08/05/2014, it was reported the injured worker complained of right shoulder, right elbow, right wrist, and right foot pain. She rated her right wrist and elbow pain 3/10 in severity. She rated her foot pain 6/10 in severity. In the physical examination, the provider noted the injured worker's right shoulder range of motion was decreased with flexion at 120 degrees and extension at 130. There was tenderness noted over the acromioclavicular joint. The provider requested diclofenac/lidocaine 3%; however, rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/Lidocaine 3%/5% 180g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for diclofenac/lidocaine 3%/5% 180 g is not medically necessary. The California MTUS/ACOM Guidelines note topical NSAIDS are recommended for osteoarthritis and tendinitis, in particular knee, elbow, and other joints are amenable. Topical NSAIDS are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the frequency and treatment site. Therefore, the request is not medically necessary.