MAXIMUS Federal Services

Case Number:	CM15-0105317		
Date Assigned:	06/09/2015	Date of Injury:	06/20/2013
Decision Date:	07/10/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	06/01/2015

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, Indiana, Oregon
Certification(s)/Specialty: Orthopedic Surgery

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 53 year old male, who sustained an industrial injury on 06/20/2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having de Quervain's with tenosynovitis on the left and left wrist muscle strain. Treatment and diagnostic studies to date has included magnetic resonance imaging of the left wrist, use of a splint, medication regimen, and corticosteroid injection. In a progress note dated 03/16/2015 the treating physician reports recurrent symptoms of pain to the left radial wrist and left hand pain. Examination reveals tenderness to the left radial wrist and a positive Finkelstein's sign on the left. The injured worker's pain level is rated a 2 out of 10, but the documentation provided did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of the current medication regimen. Also, the documentation provided did not indicate if the injured worker experienced any functional improvement with use of his current medication regimen. The medical records also lacked documentation of the injured worker's current medication regimen. The treating physician requested the topical medication of Voltaren Topical gel 1% with one refill, but the documentation did not indicate the specific reason for the requested medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Topical gel 1% 1 refill: 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 NSAIDs Page(s): 111-112.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, page 111-112, NSAIDs, states that Voltaren Gel is, 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. It is recommended for tendinitides in the same areas. Although voltaren gel would be recommended in this case initially, there is no evidence in the exam note from 2/16/15 that the previous voltaren gel has had good effect warranting a refill. Based on the request is not medically necessary.