

Case Number:	CM15-0012502		
Date Assigned:	01/30/2015	Date of Injury:	02/28/2008
Decision Date:	03/18/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/21/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 male who sustained an industrial injury reported on 2/28/2008. He has reported constant bilateral hand pain. The diagnoses have included complex regional pain syndrome; foot fracture; peripheral neuropathy; causalgia of lower limb; and bilateral carpal tunnel syndrome. Treatments to date have included consultations; diagnostic laboratory and imaging studies; bone scan of the right foot (2009); arthroscopic knee surgery; physical therapy; night hand splints; and medication management. The work status classification for this injured worker (IW) was not stated to be noted in another document that was not available for my review; however, the progress notes dated 12/19/2014 state an 8/17/2009 decision for work restrictions. On 12/30/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/19/2014, for Voltaren 1% Gel, as prescribed for pain control. The Medical Treatment Utilization Schedule, chronic pain medical treatment, topical analgesics, was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1%Gel, as prescribed on 12/19/2014: 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): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is a topical analgesic. It 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 short-term use (4-12 weeks) for arthritis. In this case, the claimant had been on the gel for several months for foot pain. There are diminishing effects after 2 weeks and long-term use is not indicated. The Voltaren gel is not medically necessary.