

Case Number:	CM15-0117351		
Date Assigned:	06/25/2015	Date of Injury:	12/12/2013
Decision Date:	07/27/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/17/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 (IW) is a 40-year-old female who sustained an industrial injury on 12/12/2013. Diagnoses include chronic severe right wrist pain; right forearm pain; right hand pain; and status post right triangular fibrocartilage complex (TFCC) repair with residual right wrist internal derangement (shown on new MRI). Treatment to date has included medications, physical therapy, splinting, injections and surgery. A Follow-Up Pain Management Evaluation Report dated 3/27/15 noted the IW had pain in the right wrist rated 4-5/10, for which she was taking Etodolac with partial benefit. The medication was causing some gastrointestinal upset. Topical Flurbiprofen 20% cream and Lidocaine 5% cream were prescribed for pain. According to the Follow-Up Pain Management Evaluation Report dated 5/28/15, the IW reported chronic, recurrent right wrist pain. It was noted an MRI showed additional internal derangement. On examination, there was tenderness over the distal aspect of the radial and carpal bone and limited range of motion of the right wrist, with 50% of normal flexion and extension. Supination was difficult. Phalen's, Tinel's and Finkelstein's signs were negative. A request was made for Voltaren 1% gel cream 200 gm for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel cream 200 gm: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

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

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). In this case, the injured worker is already prescribed oral NSAIDs and states she has GI upset with its use; therefore, a topical formulation may be more appropriate in this case. The request for Voltaren 1% gel cream 200 gm is determined to be medically necessary.