

Case Number:	CM15-0124058		
Date Assigned:	07/08/2015	Date of Injury:	01/23/2014
Decision Date:	08/05/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/26/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 is a 47 year old female, who sustained an industrial injury on 01/23/2014. She has reported injury to the left hand/wrist. The diagnoses have included left wrist pain; tenosynovitis left wrist; and congenital Madelung deformity. Treatment to date has included medications, diagnostics, ice, splinting, occupational therapy, physical therapy, and home exercise program. Medications have included Pennsaid 2% Solution. A progress report from the treating physician, dated 05/19/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of persistent left wrist and hand pain; the pain is rated at 6/10 in severity; the pain is burning and stabbing type of pain with intermittent numbness in the left hand; she is currently working and reports repetitive activity and lifting aggravates her left wrist pain; she also has some right wrist and left shoulder pain; and she wants to modify her limitations so she does not have to do repetitive work with the left hand. Objective findings included she is tearful; positive for anxiety and depression; she is grossly protective of the left upper extremity; tenderness is noted in the left wrist joint; and left wrist range of motion is limited, which is associated with pain. The treatment plan has included the request for Voltaren Gel 1% 2-4gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 2-4gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NONSELECTIVE NSAIDS Page(s): 111, 107.

Decision rationale: Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111) topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as lumbar spine pain and Knee pain. There is no documentation as to why the patient requires topical NSAID as opposed to oral medications. Therefore request for Voltaren gel 1% 2-4gm is not medically necessary.