

Case Number:	CM13-0015602		
Date Assigned:	10/09/2013	Date of Injury:	05/19/2009
Decision Date:	01/08/2014	UR Denial Date:	07/28/2013
Priority:	Standard	Application Received:	08/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and Texas. 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 physician 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 patient is a 54-year-old male who reported an injury on 05/19/2009. The patient is currently diagnosed with chronic low back pain, bilateral sciatic pain, lumbar degenerative disc disease, SI joint syndrome, and pain related insomnia. The patient was seen by [REDACTED] 09/16/2013. Physical examination revealed slight tenderness in the lower lumbar spine overlying the facet joints, paraspinal tenderness, negative straight leg raising bilaterally, 2+ deep tendon reflexes, and 5/5 motor strength in all major muscle groups. There was slight paresthesia noted at the anterolateral aspect of the right thigh. Treatment recommendations included continuation of current medications and a followup visit with [REDACTED] regarding infectious issues.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%: 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 Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have

failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Voltaren gel. It is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. The patient does not maintain a current diagnosis of osteoarthritis. The medical necessity for the requested medication has not been established. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.