

Case Number:	CM13-0016026		
Date Assigned:	03/12/2014	Date of Injury:	10/23/2012
Decision Date:	04/24/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	08/23/2013

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. The expert reviewer is Board Certified in Family Medicine, and is licensed to practice in California. 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/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 request for lumbar epidural steroid injection at L5-S1 is not medically necessary. Regarding epidural steroid injections, the Chronic Pain Medical Treatment Guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there is no evidence of nerve root impingement on MRI and the patient has normal neurologic examination findings. As such, in the absence of objective focal neurologic deficits in a dermatomal and myotomal pattern on clinical examination corroborated with imaging studies, the patient would not be an appropriate LESI candidate.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTION L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 45-46.

Decision rationale: The request for lumbar epidural steroid injection at L5-S1 is not medically necessary. Regarding epidural steroid injections, the Chronic Pain Medical Treatment Guidelines

state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there is no evidence of nerve root impingement on MRI and the patient has normal neurologic examination findings. As such, in the absence of objective focal neurologic deficits in a dermatomal and myotomal pattern on clinical examination corroborated with imaging studies, the patient would not be an appropriate LESI candidate.

VOLTAREN GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 110-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Pain Chapter, Voltaren Gel (diclofenac) Section.

Decision rationale: The request for Voltaren gel is not medically necessary. The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines further state that NSAIDs (non-steroidal anti-inflammatory drugs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Furthermore, references state that there are no long-term studies of the effectiveness or safety of topical NSAIDS for chronic musculoskeletal pain, In this case, the patient is far into the chronic phase injury, and topical NSAIDS would not be supported. Additionally, the Chronic Pain Medical Treatment Guidelines state 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. In this case, it appears that Voltaren gel was to be applied to the lumbar spine as the August 5, 2013 report only noted an examination of the lumbar spine. Furthermore, as noted in ODG, Voltaren Gel (diclofenac) is not recommended as a first-line treatment. Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. There is no indication in this case that the patient has failed oral NSAIDS. Lastly, according to FDA MedWatch, post-marketing surveillance of Voltaren Gel has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. Some of these reported cases resulted in fatalities or liver transplantation. (FDA, 2011) For these reasons, Voltaren gel is not medically necessary. The request for Voltaren Gel is not medically necessary or appropriate.