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| Case Number: | CM13-0021798 | | |
| Date Assigned: | 11/13/2013 | Date of Injury: | 02/02/2008 |
| Decision Date: | 02/05/2014 | UR Denial Date: | 08/21/2013 |
| Priority: | Standard | Application Received: | 09/09/2013 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 44-year-old male who reported an injury on 02/02/2008. The patient is currently diagnosed with postoperative repeat laminotomy and foraminotomy; status post left laminotomy and Transforaminal Lumbar Interbody Fusion in 2012, postlaminectomy syndrome, failed back surgery syndrome, and L5 radiculopathy. The patient was seen by [REDACTED] on 08/20/2013. Physical examination revealed well healed surgical scar, tenderness to palpation over the left paravertebral spine and muscles with spasm and trigger points, limited range of motion, and positive straight leg raising on the left. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel #3 Pack (DOS 7/30/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are

primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical NSAID is diclofenac, or Voltaren gel. It is indicated for relief of osteoarthritis pain and has not been evaluated for treatment of the spine, hip, or shoulder. As per the clinical notes submitted, the patient does not maintain a diagnosis of osteoarthritis. The patient has continuously utilized this topical analgesic. Despite the ongoing use, the patient continues to report 7-8/10 pain. Satisfactory response to treatment has not been indicated. As guidelines do not recommend topical Voltaren gel for treatment of the spine, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.