MAXIMUS Federal Services

Case Number:	CM13-0056156		
Date Assigned:	02/21/2014	Date of Injury:	08/17/2009
Decision Date:	05/02/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/21/2013

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 Physical Medicine and Rehabilitation, 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 injured worker is a 50-year-old male who reported an injury on 08/16/2009. The mechanism of injury was not stated. The injured worker is currently diagnosed with lumbar radiculopathy, lumbar degenerative disc disease, cervical pain, and low back pain. The injured worker was evaluated on 11/13/2013. The injured worker reported persistent neck pain with radiation to bilateral upper extremities as well as low back pain with radiation to the right lower extremity. The injured worker has been previously treated with acupuncture and chiropractic therapies. Physical examination revealed restricted range of motion of the cervical spine, spasm and tenderness, positive Spurling's maneuver, and decreased triceps reflex. Physical examination of the lumbar spine revealed restricted range of motion, spasm and tenderness, positive straight leg raising bilaterally, and intact sensation. Treatment recommendations included a prescription for Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN 1% GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

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

Decision rationale: The California MTUS Guidelines state the only FDA-approved topical NSAID is Voltaren gel 1%, which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the spine, hip, or shoulder. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency or quantity listed in the current request. Based on the clinical information received, the request is non-certified.