

Case Number:	CM14-0111871		
Date Assigned:	08/01/2014	Date of Injury:	12/10/2008
Decision Date:	11/12/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/17/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 57 years old female who sustained an industrial injury on 12/10/2008. The mechanism of injury was she tripped resulting in a right knee abrasion and injuries to both hands. Her diagnoses included low back pain s/p lumbar fusion s/p discectomies, lumbar degenerative disc disease, and cervical degenerative disc disease with stenosis, bilateral sacroiliitis, right shoulder pain and right knee pain s/p arthroscopy. She continues to complain of low back pain with radiation to the left thigh. On physical exam there is tenderness to palpation over the SI joints with positive SI loading bilaterally; lumbar range of motion is decreased in all planes, sensation and motor exams are normal in the lower extremities. There is positive straight leg raise on the left and a positive FABER bilaterally as well as a positive One Legged Stork Test and Gaenslen's, greater on the left. Treatment in addition to surgery has included medical therapy. The treating provider has requested Voltaren Gel 1 % 2-4 g topical with 5 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% 2-4g topical with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 64,70. Decision based on Non-MTUS Citation ODG Pain Chapter, Voltaren Gel

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

Decision rationale: The documentation indicates that the claimant has chronic neck, shoulder pain and back pain. She is maintained on medical therapy which includes a topical non-steroidal anti-inflammatory medication, Voltaren Gel 1%. Per California MTUS Guidelines, topical non-steroidal anti-inflammatory medications are used for the treatment of osteoarthritis particularly the knee. There is little evidence that supports them as a treatment option for spine, neck and shoulder conditions. The duration of effect is for a period of 4 to 12 weeks with reported diminished effectiveness over time. The documentation indicates the patient has liver enzyme changes consistent with a fatty liver and per the guidelines topical non-steroidal anti-inflammatory medications increase the risks of severe hepatic reactions. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.