MAXIMUS Federal Services

Case Number:	CM14-0121448		
Date Assigned:	08/06/2014	Date of Injury:	10/27/2006
Decision Date:	09/16/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/01/2014

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 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 41 year old male who reported an injury on 10/27/2008 due to repetitive movement. The injured worker complained of constant low back pain and right leg pain, and indicated that the pain was not being well-controlled. He rated the pain at 7/10 without medications and 5/10 with the pain medications. His pain was aggravated by sitting, standing, walking, bending, and lifting. The pain was alleviated by lying down and use of pain medication. The injured worker's diagnoses were thoracic disc herniation, thoracic degenerative disc disease, and postlaminectomy syndrome of the lumbar spine, lumbar radiculopathy, and chronic pain syndrome. The injured worker's prior diagnostics include MRI of the thoracic spine, which showed broad-based left paracentral disc protrusion at T12-L1 with mild narrowing of the left lateral recess. Surgical history includes L5-S1 fusion, lumbar discectomy, anterior decompression, fusion, and laminectomy. The injured worker's medications were hydrocodone, Lidoderm patches and Voltaren gel. On physical examination dated 10/10/2013, there was slight subjective decreased sensation of the right T8-T10 dermatome. Objective findings included normal dorsal kyphosis and lumbar lordosis. Lumbar flexibility was normal with pain at the extreme of lumbar flexion and lateral flexion. Lower extremity examination demonstrated motor strength of 5/5 in all muscle groups. The provider's treatment plan is for future thoracic MRI to investigate his right side chest wall and thoracic abdominal wall tingling, and chronic pain in new areas of the thoracic spine. The Request for Authorization form was not submitted with documentation provided for review. The rationale for the request was not submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% day supply:30 QTY:300: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-112.

Decision rationale: According to documentation submitted, the injured worker has a history of right chest abdominal wall area discomfort with numbness and tingling and pain in his leg. The injured worker rated his pain at 7/10 without medication and 5/10 with medication. According to the MTUS Chronic Pain Guidelines, Voltaren gel is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment to include ankles, elbows, feet, hands, knees, and wrists. The injured worker is complaining of constant low back pain and right leg pain. The Guidelines state that Voltaren gel has not been evaluated for treatment of the spine, hip, or shoulder. The request is not supported by the MTUS Chronic Pain Guidelines. Additionally, the request does not specify the location for use. Furthermore, the request does not include the frequency for the proposed medication. As such, the request is not medically necessary and appropriate.