

Case Number:	CM14-0122372		
Date Assigned:	08/06/2014	Date of Injury:	01/10/2005
Decision Date:	09/11/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/04/2014

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 Occupational 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 patient is a 47-year-old female who has submitted a claim for chronic low back pain, s/p hemilaminectomy at L5-S1 with epidural fibrosis, facet arthropathy, and markedly narrowed left neuroforamen, multilevel lumbar degenerative disc disease with central canal and neural foraminal stenosis, transitional anatomy at the lumbosacral junction with mild hyperlordosis, bilateral lower extremity radicular pain and weakness, bilateral knee pain, associated with an industrial injury date of January 10, 2005. Medical records from 2013 through 2014 were reviewed. The latest progress report, dated 07/08/2014, showed low back pain and weakness in her bilateral lower extremities. There was significant pain rated as 8/10 with medications and 10/10 without medication. Physical examination revealed that patient was able to stand and ambulate with an assistive device. Muscle tightness and tenderness of the lumbar spine were noted. Treatment to date has included hemilaminectomy L5-S1, shoulder surgery, physical therapy, trigger point injections, aquatic therapy, and medications including oral and topical which included Voltaren gel since December 2013. Utilization review from 08/04/2014 denied the request for the purchase of Voltaren 1% gel 4g because guidelines recommended it for treatment of knee osteoarthritis, for use up to 12 weeks. However, the claimant has completed a trial of Voltaren gel, but further information was required concerning symptomatic or functional response to this medication in order to determine the medical necessity for continuation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel 4 grams.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: According to page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, the earliest evidence of Voltaren gel use was December 2013. Voltaren was prescribed for knee pain. However, the use of Voltaren is not in accordance with guideline recommendations as there was no evidence of osteoarthritis of the knee. Furthermore, there was no documented evidence of the functional benefits obtained with previous usage. Moreover, the prescribed quantity was not specified. The request was incomplete. Therefore, the request for Voltaren gel 1% 4 grams is not medically necessary.