MAXIMUS Federal Services

| Case Number: | CM14-0127105 | | |
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| Date Assigned: | 08/13/2014 | Date of Injury: | 11/02/1994 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 07/23/2014 |
| Priority: | Standard | Application Received: | 08/11/2014 |

## 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 Family Medicine and is licensed to practice in Tennessee, California, and 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 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 59-year-old male injured on 11/21/94. Diagnoses include chronic back pain and right L4-5 facet pain. Clinical note dated 07/17/14 indicated the injured worker presented for routine evaluation of chronic back pain. The injured worker continued to be treated conservatively with aquatic gym membership where Jacuzzi, sauna, and treadmill were utilized 6 times per week allowing for core strengthening and maintaining of normal body weight. Objective findings included pain with back flexion/extension, ability to toe and heel walk, motor strength 5/5 bilaterally, no numbness or tingling to the bilateral lower extremities, reflexes 2+ bilaterally, straight leg raising causes back discomfort, paraspinal muscle spasm and tenderness, Babinski reflexes are down going, and direct palpation at the right L4-5 facet noticeably enlarged and very painful. Treatment included continuation with aquatic therapy program, renewal of Tramadol for pain relief, lumbar back support, and prescription for Pennsaid. The initial request for Pennsaid 2% was initially non-certified on 07/23/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Pennsaid 2%:** Upheld

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

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

**Decision rationale:** Pennsaid is a topical non-steroidal anti-inflammatory drug or NSAID (Diclofenac). As noted on page 112 of the Chronic Pain Medical Treatment Guidelines, Voltaren Gel (Diclofenac) is not recommended as a first-line treatment. Diclofenac is recommended for osteoarthritis after failure of an oral NSAID, contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with Diclofenac, including topical formulations. According to FDA MedWatch, post-marketing surveillance of Diclofenac has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. With the lack of data to support the superiority of Diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered. As such the request for Pennsaid 2% cannot be recommended as medically necessary at this time.