

Case Number:	CM14-0178701		
Date Assigned:	11/03/2014	Date of Injury:	07/05/2002
Decision Date:	12/08/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/28/2014

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, has a subspecialty in Pain 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 injured worker is a 73 year-old male with a date of injury of 7/5/2002. The patient's industrially related diagnoses include chronic myoligamentous lumbar spine strain/sprain, multilevel lumbar spondylosis, left sided lumbar radiculopathy, lumbar disc protrusion, and lumbar degenerative disc disease. The patient was treated with ibuprofen but could not tolerate medication due to GI upset. The patient has been using Voltaren topical gel and Lidoderm Patch since 2012, with the most recent prescription being January 2014 and May 2014 respectively. The disputed issues are the request for refill of Voltaren gel 3%, and Lidoderm patches 5%. A utilization review determination on 9/30/2014 had non-certified these requests. The stated rationale for the denial for Voltaren gel was lack of documentation of pain and functional improvement from prior use. The rationale for denial for Lidoderm Patch was the lack of documentation of pain and functional improvements, and the lack of evidence of trial of first line therapy prior to the treatment with Lidoderm patches. Therefore, both of these requests are non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 prescription of Voltaren gel 1% three tubes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on page 112 state the following: "Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren package insert) For additional adverse effects: See NSAIDs, GI symptoms and cardiovascular risk; & NSAIDs, hypertension and renal function." Based on the guidelines stated above, Voltaren topical gel 1% has not been re-validated for the treatment of the spine, hip, or shoulder. The patient has predominantly problem in his lumbar spine as a result of degenerative disc disease, radiculopathy, and disc protrusion. The patient has contraindication to taking oral NSAIDs due to GI side effects, however, a short term of 4-12 weeks is typically recommended for topical NSAIDs. The patient has been on this medication since 2012 without clear objective finding of significant functional or pain improvement. Therefore, the request for continuation of Voltaren Gel 1% is not medically necessary.

Prospective request for 1 prescription of Lidoderm patch 5%, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: Regarding request for topical Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or anti-epileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed Lidoderm. As such, the currently requested Lidoderm is not medically necessary.