

<b>Case Number:</b>	CM14-0062719		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/23/2012
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Texas. 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 56 year old male who had a work related injury on 01/23/12. It was a lifting injury injuring his neck and his lower back. The injured worker has tried taking Motrin, Aleve, and Flexeril with no relief of symptoms. EMG/NCV study of the right upper and right lower extremities on 05/09/14 showed abnormal study, electrodiagnostic evidence of moderate demyelinating median neuropathy across right wrist. There is no electrodiagnostic evidence of right upper extremity radiculopathy, plexopathy, or other mononeuropathy. Cervical spine MRI dated 04/01/14 decreased disc height, degenerative marrow changes, anterior and posterior osteophytes, with questionable mild retrolisthesis at C5-6 level. Associated mild spinal stenosis and moderate bilateral foraminal stenosis at this level. 1mm disc bulge at C6-7 without cervical spinal cord or nerve root compression identified. Questionable minimal anterolisthesis at C4-5 level with degenerative changes seen involving the left C4-5 facet joint. MRI of the lumbar spine dated 11/12/13 shows right sided disc extrusion at L5-S1 level encroaching upon the ventral aspect of the thecal sac and abuts the descending right S1 nerve root. Disc desiccation with 2-3mm disc bulge slightly eccentric towards the left noted at L4-5. The most recent medical record submitted for review is dated 07/11/14. The injured worker is in the office today for neck pain radiating from the neck down to the right arm. Back pain radiating from the low back down the right leg and lower back ache. Physical examination the injured worker appears to be calm and in mild to moderate pain. He does not show signs of intoxication or withdrawal. The injured worker does not use assistive devices. Cervical spine examination no lordosis, asymmetry, or abnormal curvature noted on this injured worker's cervical spine. Range of motion is restricted with flexion limited to 35 degrees, extension limited to 30 degrees, right lateral bending and left lateral bending limited to 15 degrees. There is some spasm and tenderness and tight muscle band is noted on both sides of the paravertebral muscles. Spinous

process tenderness is noted at C5, C6, and C7. Tenderness is noted at the paracervical muscles, rhomboids, and trapezius. Spurling's maneuver causes pain in the muscles of the neck but no radicular symptoms. Biceps, triceps, and brachial radialis reflexes 2 bilaterally. Lumbar spine range of motion is restricted with flexion limited to 50 degrees, extension limited to 10 degrees limited by pain. Right and left lateral bending is limited to 10 degrees. Paravertebral muscles, spasms, tenderness, and tight muscle band is noted on both sides of the paravertebral muscles. Lumbar facet loading is positive on both sides. Straight leg raising test is negative. Ankle jerk and patellar knee jerks are 2+ on both sides. Strength in the right EHL is rated 4/5 to manual motor testing and left EHL is rated 3/5. Light touch sensation is decreased over the posterior thigh in C6 bilaterally. Diagnoses lumbar facet syndrome. Low back pain. Cervical facet syndrome. Cervical pain. Prior utilization review dated 04/25/14 was non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Voltaren 1% gel apply 2 inch strip to affected area twice a day, as needed #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 112.

**Decision rationale:** 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 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 this is not medically necessary.