

Case Number:	CM14-0063552		
Date Assigned:	07/11/2014	Date of Injury:	06/29/2000
Decision Date:	09/08/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/06/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 71 year old female injured on 06/29/00 due to undisclosed mechanism of injury. Diagnoses included low back pain with left leg symptoms, bilateral shoulder pain with decompression, left knee pain with degenerative joint disease, bilateral elbow pain with shoulder tendinopathies, lateral medial epicondylitis, and chronic tendinitis in the wrists. Clinical note dated 03/26/14 indicated the injured worker presented complaining of worsening back pain radiating to the left lower extremity. Recent MRI revealed interval change with worsening compromise of the left S1 nerve root due to disc herniation. Injured worker rated pain 7 to 9/10. Medications included Tylenol number 3, Celebrex, Flector patches, and Ambien. The injured worker also utilized Voltaren gel for myofascial shoulder pain. Physical examination revealed decreased range of motion in the lumbar spine, altered sensory examination in the left lateral calf and bottom of the foot, difficulty ambulating on heels and toes, deep tendon reflexes 1+ at knees and ankles, toes were downgoing to plantar reflex bilaterally. Physical examination of bilateral shoulder revealed limited range of motion in all planes with positive impingement signs and crepitus on circumduction bilaterally. The initial request for Voltaren gel 1 percent 100 gram quantity three was noncertified on 04/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 100 Grams Quantity Three: Upheld

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

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

Decision rationale: As noted in 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 non-steroidal anti-inflammatories drug (NSAID), contraindications to oral NSAIDs, or for patients who cannot swallow oral forms, and after considering the increased risk profile with diclofenac, including topical formulations. 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 Voltaren gel 1 percent 100 grams quantity three is not medically necessary at this time.