

Case Number:	CM14-0085386		
Date Assigned:	08/08/2014	Date of Injury:	03/22/1999
Decision Date:	10/03/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/09/2014

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 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 63-year-old female who reported injury on 03/22/1999 caused by an unspecified mechanism. The injured worker's treatment history included pain medications and topical creams. The injured worker was evaluated on 05/06/2014, it was documented the injured worker complained of low back pain. Radiation of the pain was to both lower extremities, both buttocks, and both hips. Pain was bilateral, left greater than right. The injured worker complained of persistent, chronic lumbar region, bilateral buttock, and bilateral left greater than right lower extremity pain. She had lumbar degenerative disc disease L5-S1 with significant retrolisthesis, bilateral lower extremity radiculitis L5, diffuse regional myofascial pain and chronic pain syndrome with both sleep and mood disorder. Physical examination: the provider noted the injured worker was overweight; level of distress, there was none noted. There were muscle aches and weakness, arthralgia's/joint pain both knees, and back pain, no swelling in the extremities. Medications included Ativan, Lyrica, Lidoderm patches, and Voltaren 1% topical gel. Diagnoses included displacement of lumbar intervertebral disc without myelopathy, chronic pain syndrome, and psychophysiological disorder. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patch 5% #30 with 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

Decision rationale: The injured worker is a 63-year-old female who reported injury on 03/22/1999 caused by an unspecified mechanism. The injured worker's treatment history included pain medications and topical creams. The injured worker was evaluated on 05/06/2014, it was documented the injured worker complained of low back pain. Radiation of the pain was to both lower extremities, both buttocks, and both hips. Pain was bilateral, left greater than right. The injured worker complained of persistent, chronic lumbar region, bilateral buttock, and bilateral left greater than right lower extremity pain. She had lumbar degenerative disc disease L5-S1 with significant retrolisthesis, bilateral lower extremity radiculitis L5, diffuse regional myofascial pain and chronic pain syndrome with both sleep and mood disorder. Physical examination: the provider noted the injured worker was overweight; level of distress, there was none noted. There were muscle aches and weakness, arthralgia's/joint pain both knees, and back pain, no swelling in the extremities. Medications included Ativan, Lyrica, Lidoderm patches, and Voltaren 1% topical gel. Diagnoses included displacement of lumbar intervertebral disc without myelopathy, chronic pain syndrome, and psychophysiological disorder. The Request for Authorization was not submitted for this review.

Volteren Gel 1% #300 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Voltaren Gel 1 % Page(s): 112.

Decision rationale: The request is not medically necessary. The California MTUS Guidelines state that Voltaren Gel 1% (Diclofenac) is recommended 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. The documents submitted lacked outcome measurements of medication management and home exercise regimen. In addition, the request lacked frequency, duration, and location where the medication is supposed to be applied for the injured worker. Given the above, the request for Voltaren gel 1% # 300 with 1 refill is not medically necessary.