

Case Number:	CM14-0182126		
Date Assigned:	11/07/2014	Date of Injury:	09/10/1985
Decision Date:	01/23/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/03/2014

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 Management and is licensed to practice in Tennessee. 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:

This is a 63-year-old female with a 9/10/85 date of injury. According to a progress report dated 5/12/14, the patient complained of worsened low back pain that radiated down the bilateral lower extremities. She stated that she had less nausea/GI upset. She rated her pain as a 9/10 with medications and as a 10/10 without medications. Motrin was not as effective as Voltaren gel, which was not approved. Objective findings: tenderness upon palpation in the spinal vertebral area L4-S1 levels, moderately limited range of motion of the lumbar spine secondary to pain. Diagnostic impression: failed back surgery syndrome (lumbar), lumbar radiculopathy, status post lumbar spine fusion. Treatment to date: medication management, activity modification, pool therapy, physical therapy, TENS unit. A UR decision dated 10/16/14 denied the request for Voltaren gel. A specific rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel, 1-2gm TID, 300gm, 1 refill: Upheld

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

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

Decision rationale: CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. However, in the present case, there is no documentation that this patient has an arthritic component to her pain. In addition, there is no documentation that she is unable to tolerate oral NSAID medications. Therefore, the request for Voltaren 1% gel, 1-2gm TID, 300gm, 1 refill was not medically necessary.