

Case Number:	CM14-0191610		
Date Assigned:	11/25/2014	Date of Injury:	07/30/2003
Decision Date:	01/13/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/17/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine Pain Management 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 patient is a 58-year-old female with date of injury of 07/30/2003. The listed diagnosis from 10/07/2014 is spondylosis, lumbosacral. According to this report, the patient complains of neck, upper extremity and low back pain. She also complains of low back pain that radiates into the back of both lower extremities. The patient reports numbness and tingling intermittently in both legs. She reports her pain is worse with walking especially the radicular pain. The examination shows that the patient complains of headaches, but denies dizziness. She also complains of balance problems, poor concentration, memory loss, numbness and weakness, but denies seizures and tremors. No other findings were noted on this report. The documents include an MRI of the lumbar spine from 11/10/2014 and progress reports from 04/08/2014 to 11/20/2014. The utilization review denied the request on 10/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Voltaren gel 1% #4, DOS: 10/7/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

Decision rationale: This patient presents neck, upper extremity and low back pain. The provider is requesting a retrospective Voltaren Gel 1% quantity 4, DOS 10/07/2014. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. It is, however, indicated for short term use, between 4-12 weeks. It is indicated for patient with Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The records do not show a history of Voltaren Gel use. It would appear that the provider is prescribing this medication for the patient's neck and low back pain. Topical NSAIDs are only recommended for patients with Osteoarthritis and tendinitis of the knee, elbow or other joints amenable to topical application. The request is not medically necessary.