

Case Number:	CM14-0194925		
Date Assigned:	12/02/2014	Date of Injury:	03/15/2007
Decision Date:	01/16/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/20/2014

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 Emergency Medicine, and is licensed to practice in Wisconsin. 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 51 year old female with a date of injury as 03/15/2007. The cause of injury was not included in the documentation. The current diagnoses include lumbosacral spondylosis without myelopathy and cervical spondylosis without myelopathy. Previous treatments include oral pain medications, physical therapy, home exercises and strengthening, and trigger point injections. Primary treating physicians report dated 04/21/2014, 08/15/2014, and 11/07/2014 were included in the documentation submitted for review. Report dated 11/07/2014 notes that the injured worker presented with complaints that included pain located in the neck and bilateral shoulders, described as sharp and aching, pain radiates down bilateral shoulders. The degree of pain was rated as 8 out of 10 without medication, the pain improves with medications and heat. The pain is aggravated by looking around, activity, and movement. Physical examination revealed decreased Range of Motion (ROM) in the cervical spine with pain, and tenderness to palpation over the cervical paraspinals. Treatment recommendations included continuing with the Voltaren gel. Primary treating physician report dated 04/21/2014 and 08/15/2014 notes that the injured worker was prescribed and using Voltaren gel. The documentation submitted shows that the injured worker has been using the Voltaren gel since 04/21/2014. It was documented in the primary treating physician report from 04/21/2014 that the Voltaren gel does help to decrease pain, but the physician did not provide a detailed evaluation of functional improvement. None of the other documentation submitted evaluated the requested item for efficacy or noted the functional improvements while using this medication. The injured worker is not working. The utilization review performed on 11/18/2014 non-certified a prescription for Voltaren 1% topical gel, three per month based on no documented efficacy of the medication with a quantitative decrease in pain and an objective improvement in function with use. Also it was unclear how long the injured worker had been using the medication and without

this information, a continuation would not be supported as the medication is only recommended for short term treatment. The reviewer referenced the California MTUS in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% topical gel, three per month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren 1% topical gel, 3 per month, is not medically necessary. According to the California MTUS Guidelines, topical analgesics are extremely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Voltaren gel 1% may be indicated 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. Maximum dose should not exceed 32 g per day. The injured worker complained of pain located in the neck and bilateral shoulders. She rated the severity of her pain without pain medications 8/10 on average. The pain was improved with medications and heat. The injured worker was documented to have decreased range of motion in the cervical spine with pain and tenderness to palpation over the cervical paraspinals. The documentation did not provide sufficient evidence of a significant objective improvement in function or pain as a result of the topical gel. The documentation indicates that the patient has been prescribed Voltaren 1% topical gel since at least 04/21/2014. In the absence of documentation with sufficient evidence of significant objective functional improvement and decrease in pain as a result of the medication use, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.