

Case Number:	CM14-0202579		
Date Assigned:	12/15/2014	Date of Injury:	04/27/2001
Decision Date:	01/31/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/03/2014

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 Internal Medicine, has a subspecialty in Rheumatology, Allergy and Immunology 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:

This is a 68 year old female with a date of injury of 04/27/01. She is being treated for complex regional pain syndrome of the left lower extremity, lumbar disc disease, lumbar radiculopathy, fibromyalgia, osteoarthritis, headaches and self-reported GERD symptoms. Subjective findings from the most recent provided exam include neck pain radiating down bilateral upper extremities, low back pain radiating down bilateral lower extremities, bilateral knee pain and insomnia. Objective findings include tenderness on palpation in the spinal vertebral area L4-S1, pain increase with flexion and extension, and facet sign were present bilaterally. X-ray right hip on 02/25/14 was negative. MRI of the lumbar spine on 04/10/02 showed degenerative changes of facet joints at L4-L5 and L5-S1. MRI of the cervical spine on 04/10/02 demonstrated vertebral endplate hypertrophic changes with disc space narrowing and calcified encroachment on the anterior spinal canal and inferior neural foraminal areas at C5-C6. An EMG on 02/07/02 of the lower extremities was negative but NCS at the same time revealed a right S1 radiculopathy, left L5 radiculopathy, left median nerve neuropathy in consistent with carpal tunnel syndrome and possibly C6-C7 radiculopathy or brachial plexopathy. Treatment has consisted of medications (Voltaren 1 % gel, Fioricet, chlorazepate, gabapentin, hydrocodone/APAP, pantoprazole, restone, vitamin D, doxepin) and acupuncture. The Utilization Review on 11/04/14 was non-certify for Voltaren 1% gel as there is poor evidence for use in this disorder and no evidence that she has failed antidepressants or anticonvulsants.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel #30: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Compound creams.

Decision rationale: California MTUS and Official Disability Guidelines (ODG) recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. She is currently on a low dose doxepin at bedtime for sleep only. She has not been prescribed another antidepressant as noted in the records. California MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Voltaren (Diclofenac) (recommended for OA) MTUS specifically states for Voltaren Gel 1% (diclofenac) that it "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." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints with this medication. Additionally, the records fail to indicate where and what treatment area would be for Voltaren. As such, the request for Voltaren 1 % gel is not medically necessary.