

<b>Case Number:</b>	CM15-0003351		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	04/09/2009
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 female, who sustained an industrial injury on 04/09/2009. On provider visit 12/04/2014 she has reported moderated to severe right knee pain, and unable to bear weight on it. The diagnoses have included disc disorder lumbar, lumbar facet syndrome, lumbar radiculopathy, post lumbar laminectomy syndrome, low back pain and chronic pain syndrome. Treatment plan included Cymbalta, Metaxalone, Gabapentin and Lidoderm and refill of Voltaren Gel 1% gram tube refills X2. On 12/30/2014 Utilization Review non-certified Lidoderm patch 5%, Voltaren Gel 1% with 2 refills, noting not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patch 5% # 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 Pain section, Topical analgesics

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Lidoderm patch 5% #30 is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy or safety. They are primarily recommended for treatment of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidoderm is recommended for localized pain consistent with a neuropathic etiology after evidence of a trial with first-line therapy (tricyclics or AEDs). In this case, the injured worker's working diagnoses are disc disorder lumbar; lumbar facet syndrome; lumbar radiculopathy; post lumbar laminectomy syndrome; low back pain; and chronic pain syndrome. Subjectively, the injured worker complains of right knee pain and is unable to weight bear. Symptoms are worse at night. The injured worker was canceling her spinal cord stimulator trial. Objectively, the injured worker ambulates with a cane and appears anxious, fatigued and in moderate pain. Lidoderm was prescribed as far back as July 11, 2014. It is unclear whether this is a refill for the start date for Lidoderm. The documentation does not contain evidence of objective functional improvement as it relates to the Lidoderm patch 5%. Additionally, the clinical indication is unclear based on the subjective and objective findings in the medical record. Consequently, absent clinical documentation with objective functional improvement associated with the Lidoderm patch 5%, Lidoderm patch 5% #30 is not medically necessary.

**Voltaren Gel 1% 100 gm with 2 refills:** 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 Pain section, Topical analgesics

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Voltaren gel 1% #100 g with two refills is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy or safety. They are primarily recommended for treatment of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren (Diclofenac) gel is the only available FDA approved topical nonsteroidal anti-inflammatory drug. Diclofenac is indicated for relief of osteoarthritis pain in a joint that lends itself to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of the hip, spine or shoulder. In this case, the injured worker's working diagnoses are disc disorder lumbar; lumbar facet syndrome; lumbar radiculopathy; post lumbar laminectomy syndrome; low back pain; and chronic pain syndrome. Subjectively, the injured worker complains of right knee pain and is unable to weight bear. Symptoms are worse at night. The injured worker was canceling her spinal cord stimulator trial. Objectively, the injured worker ambulates with a cane and appears anxious, fatigued and in moderate pain. Voltaren is FDA approved for topical use and indicated for relief of osteoarthritis pain in the joint that lends itself to topical treatment. The documentation does not contain

evidence of osteoarthritis pain. Additionally, Voltaren gel has not been evaluated for treatment of the hip, spine or shoulder. The documentation indicates Voltaren gel has been used as far back as July 11, 2014. It is unclear whether this is a refill or the start of a new prescription. However, the documentation does not contain evidence of objective functional improvement associated with Voltaren gel. Consequently, absent clinical documentation to support the use of Voltaren gel in the absence of osteoarthritis related pain in contravention of the recommended guidelines, Voltaren gel 1% #100 g with two refills is not medically necessary.