

Case Number:	CM15-0007759		
Date Assigned:	01/26/2015	Date of Injury:	05/25/2008
Decision Date:	03/13/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/14/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 58 year old female who sustained a work related injury May 25, 2008. According to a supplemental orthopedic report dated August 11, 2014, the injured worker was treated based on the presence of a bulging disc at L4-5 on the left noting an MRI(magnetic resonance imaging) dated 2008(not present in the medical record). This examiner documents two levels involved; L5-S1 actually abuts the S1 nerve root displacing it therefore it is a small left L4-5 and bilateral L5-S1 disc protrusions and left lumbar radiculitis. She has received three epidurals, physical therapy and acupuncture treatment. A primary treating physician's report dated September 11, 2014, presents the injured worker with complaints of back pain and in need of medication refills. Impression is small left sided L4-L5 and bilateral L5-S1 paracentral protrusions and back pain with lumbar radiculitis. Treatment plan included refills for medications, Voltaren gel, ibuprofen, Soma, Lidoderm patch, continue with independent exercise program and return in 6 months for a recheck. There are no additional current medical records available for review. According to utilization review dated December 23, 2014, the request for Voltaren gel 1% Day Supply: 30 Qty: 100 Refills: 4 Date: 12/04/2014 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines; Topical Analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 - 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Voltaren Gel is not medically necessary per the MTUS Guidelines. The guidelines state that Voltaren Gen is 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 documentation does not indicate that the patient is using this for topical treatment of osteoarthritis in joints that lend themselves to treatment. The documentation indicate that the patient has lumbar spine pain for which Voltaren is not indicated for. The request does not list a strength or quantity therefore this request is not medically necessary.