MAXIMUS Federal Services

| Case Number: | CM15-0165245 | | |
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| Date Assigned: | 09/10/2015 | Date of Injury: | 11/20/2013 |
| Decision Date: | 10/15/2015 | UR Denial Date: | 07/29/2015 |
| Priority: | Standard | Application Received: | 08/24/2015 |

## 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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

## 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 36 year old male who sustained an industrial injury on 11-20-13. Diagnoses are lumbar radiculopathy-neuropathy, lumbar spondylosis, and lumbar myofacsial sprain-strain. Previous treatment includes medication, a home exercise program, and at least 2 sessions of physical therapy. In a progress report dated 7-22-15, the treating physician notes low back pain has not changed. He has completed 2 sessions of physical therapy. Pain management and neurology consults are pending scheduling. Medications are Duexis and Tramadol. Gabapentin was discontinued. His gait is mildly antalgic. There is tenderness to palpation over the paravertebral musculature at L4-L5 , L5-S1, and over the right buttock. Straight leg raise is positive. Work status is to remain off work for 4 weeks. A request for authorization dated 7-23-15, includes a pain management consultation and treatment and Voltaren Gel 1% for the lower extremity. The requested treatment of Voltaren Gel 1% 5-100 gram tubes with 3 refills was not approved on 7-29-15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% 5-100g Tubes; 3 Refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The patient presents with low back pain radiating down right leg via buttock. The request is for VOLTAREN GEL 1% 5-100G TUBES; 3 REFILLS. The request for authorization is dated 07/23/15. EMG/NCV of the bilateral lower extremities, 03/14/15, shows abnormal study: acute or chronic neuropathic changes in the right L2, L3, and L4 myotomes, consistent with an acute or chronic radiculopathy; a left tibial axonal motor neuropathy. Physical examination of the lumbar spine reveals TTP over paravertebral musculature, spinous process of L4-5, L5-S1, TTP over buttock right, positive SLR RLE. Patient has completed 2 sessions of PT. Pain mgmt & neuro authorized but hasn't scheduled appt. Patient's medications include Duexis and Tramadol. Per progress report dated 08/19/15, the patient to remain off-work. MTUS Guidelines, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." "...this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): “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." Treater does not specifically discuss this medication. This appears to be the initial trial prescription for Voltaren Gel. The patient continues to suffer from low back pain radiating down right leg via buttock. In this case, the patient does not present with peripheral joint arthritis/tendinitis, for which an NSAID lotion would be indicated. Therefore, the request IS NOT medically necessary.