MAXIMUS Federal Services

Case Number:	CM15-0189418		
Date Assigned:	10/01/2015	Date of Injury:	07/19/2013
Decision Date:	11/12/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/25/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 49-year-old female patient, who sustained an industrial injury on 07-19-2013. She sustained the injury due to fall. She has reported injury to the left knee and low back. The diagnoses have included chronic low back pain; disc herniation at L5-S1; and chronic left knee pain. Per the doctor's note dated 9/23/15, she had no change in pain at 9/10 without medications and 6/10 with medications. Per the progress report from the treating provider, dated 07-29-2015, she had complaints of low back pain and left knee pain; the intensity of the pain has increased; her pain was rated at 10 out of 10 in intensity today without her medications, and improves to a 7 out of 10 with her medications; the Percocet improves her pain somewhat and allows her to get some rest; the low back pain goes into the posterior left thigh and is in her left knee; the pain was described as sharp and shooting and aching in the low back with numbness and tingling in the left and dull aching pain in the left knee. Two weeks ago, she presented to an urgent care clinic where she states she had a left knee injection; and she had two days of benefit and increased ability to walk and mobilize following this injection. The physical examination revealed able to ambulate, but drastically favors her right leg and she obviously has pain in the left leg; able to stand up on her toes and heels with assistance with great pain; palpatory tenderness over the lumbar paraspinal muscles bilaterally on the left greater than the right; positive seated straight leg raise on the left; notably stronger in the right lower extremity; and decreased sensation to light touch throughout the left leg compared to the right. Medications have included Norco, Percocet, Naproxen, and Baclofen. Patient has tried cymbalta. She has had lumbar spine MRI dated 5/22/15 which revealed multilevel degenerative changes; left knee X-rays dated 10/16/2013 which revealed mild tricompartmental degenerative changes with no bony

fractures. Treatment to date has included medications, diagnostics, physical therapy, and lumbar epidural steroid injection. It is noted in the documentation that she has not had physical therapy in a number of years, and that she did not have a good response to epidural steroid injection. The treatment plan has included the request for Voltaren 1% gel #1 with 1 refill. The original utilization review, dated 08-24-2015, modified the request for Voltaren 1% gel #1 with 1 refill, to Voltaren 1% gel #1 with 0 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel #1 tube with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 10/09/15)Voltaren® Gel (diclofenac).

Decision rationale: Voltaren 1% gel #1 tube with 1 refill. The cited Guidelines regarding topical analgesics state, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed... Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." In addition, per the ODG cited above voltaren gel is "Not recommended as a first-line treatment. See Diclofenac Sodium (Voltaren), where Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations." Any intolerance or contraindication to oral medications is not specified in the records provided. The cited guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Failure of an anticonvulsant is not specified in the records provided. The medical necessity of Voltaren 1% gel #1 tube with 1 refill is not medically necessary for this patient at this time.