

Case Number:	CM15-0209959		
Date Assigned:	10/28/2015	Date of Injury:	02/22/1998
Decision Date:	12/09/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	10/26/2015

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 50-year-old female who sustained an industrial injury on 2-22-1998. A review of medical records indicates the injured worker is being treated for herniated disc left T2-3 right T6-7, chronic pain syndrome, facet arthropathy, thoracic, and history of compression fracture thoracic vertebra. Medical records dated 9-4-2015 noted thoracic pain rated an 8 out of 10. Previous pain rating was the same. Pain interferes with sleep, activities of daily living, emotions, and function. Physical examination noted severe tenderness over mid and lower thoracic area. Range of motion was limited due to pain. There was bilateral parathoracic tightness over the mid and lower thoracic area extending to the lumbar spine. There was moderate diffuse tenderness over the lower lumbar area. Extension brought pain to the lumbar area. Treatment has included Voltaren Gel since at least 3-18-2015. Utilization review form dated 10-10-2015 non-certified Voltaren 1% gel #4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% Gel #4 DOS 10/13/2015: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Topical Analgesics.

Decision rationale: Per Guidelines, Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc...) for the acute first few weeks; however, it not recommended for spinal disorders or for long-term use beyond the initial few weeks of treatment for this chronic 1998 injury. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Recent report noted chronic pain symptoms with unchanged activity level. Clinical exam is without acute changes or report of flare-up for this chronic injury. The Voltaren 1% Gel #4 DOS 10/13/2015 is not medically necessary and appropriate.