

Case Number:	CM15-0021096		
Date Assigned:	02/10/2015	Date of Injury:	12/05/2012
Decision Date:	05/01/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/04/2015

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, Hawaii
 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 66 year old male who sustained an industrial injury on 12/05/2012. Diagnosis is lumbar radiculopathy. Treatment to date has included medications, acupuncture, physical therapy, and aquatic therapy. A physician progress note dated 01/14/2015 documents the injured worker has had no significant improvement since the last exam. He continues to have significant lower back pain that radiates to his right lower extremity. Acupuncture helps temporarily. On examination of the lumbar spine, he has tender paravertebral muscles. Spasm is present and range of motion is restricted. Straight leg raising test is positive bilaterally. His greater trochanter is tender to palpation. Pressure over the piriformis produces pain. Recommended treatment is for Aqua Therapy 3 x a week for 4 weeks with massage to improve his symptoms and medications. Treatment requested is for Voltaren 1% gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel: Upheld

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

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

Decision rationale: The patient presents with low back pain with radiation to his right lower extremity. The current request is for Voltaren 1% gel. The treating physician states that there has been no significant improvement since the last exam and patient continues to have significant lower back pain that radiates to his right lower extremity. The MTUS Guidelines are specific that topical NSAIDs are "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." In this case, the treating physician has prescribed Voltaren 1% gel for the patient's low back pain with radiation to the right lower extremity. MTUS does not support the usage of Voltaren gel for treatment of the spine or radicular pain. The current request is not medically necessary and the recommendation is for denial.