

Case Number:	CM15-0040780		
Date Assigned:	03/11/2015	Date of Injury:	01/22/2002
Decision Date:	04/14/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/03/2015

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, Pain Management

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 51 year old male sustained an industrial injury to the back on 1/22/02. Previous treatment included lumbar fusion and medications. In a PR-2 dated 2/2/15, the injured worker complained of a recent flare up of back pain that led to gastric discomfort and necessitated an Emergency Department visit. Currently, the injured worker rated his pain at 9/10 on the visual analog scale with medications and 10/10 without. The pain was associated with bilateral lower extremity weakness and numbness, bowel compromise, depression, fatigue and insomnia. The injured worker reported having a bowel movement without realizing it while lying in bed and being unable to walk for more than a block without pain. Current diagnoses included chronic pain syndrome and lumbar post-laminectomy syndrome. The treatment plan included lumbar spine magnetic resonance imaging and medications (Voltaren gel, Oxycodone, Percocet and Methadone).

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 70-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Voltaren gel, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, none of the abovementioned criteria has been documented. Given all of the above, the requested Voltaren gel is not medically necessary.