MAXIMUS Federal Services

Case Number:	CM15-0051670		
Date Assigned:	03/25/2015	Date of Injury:	07/12/1999
Decision Date:	05/12/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/18/2015

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: Arizona, 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:

The injured worker is a 59 year old male, who sustained an industrial injury on 7/12/1999. Diagnoses include L3-4 and L4-5 disc herniation with right lower extremity radiculopathy, status post right total knee arthroscopy, left knee strain and probable depression-compensatory. Treatment to date has not been provided. Per the Primary Treating Physician's Progress Report dated 1/21/2015, the injured worker reported persistent back pain rated as 8/10 and bilateral knee pain rated as 7/10. Physical examination revealed abnormal toe walk on the left. There was tenderness in the paraspinous musculature of the thoracic and lumbar regions. Muscle spasm is positive in the lumbar area bilaterally. Range of motion of the lumbar spine was restricted with spasm present. Left knee inspection revealed tenderness about the medial joint line and patellar tendon. Grind maneuver was positive. The plan of care included a lumbar corset, home exercise program, and Voltaren cream and authorization was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren cream 100g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are 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 is a topical analgesic. It is 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. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant does not have the above diagnoses. The length, frequency of applications was not specified. The request for Voltaren gel is not medically necessary.