

Case Number:	CM14-0165503		
Date Assigned:	10/10/2014	Date of Injury:	01/23/2007
Decision Date:	11/12/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/08/2014

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. The expert reviewer is Board Certified in Family Medicine, and is licensed to practice in North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 68-year-old with a reported date of injury of 01/23/2007. The patient has the diagnoses of chronic low back pain, lumbar radiculitis, chronic left wrist pain, chronic left knee pain ACDF at C5-C7, major depression and right knee arthroplasty. Past treatment modalities have included cervical surgery, wrist surgery, knee surgery, epidural steroid injections, home exercise program and knee injections. Per the most recent progress notes provided for review by the primary treating physician dated 09/19/2014, the patient had complaints of constant pain in the left wrist., increased pain in the left knee, stable low back pain and moodiness. The physical exam noted tenderness in the first dorsal compartment of the left wrist, tenderness in the lateral joint line of the left knee with crepitus in the patellofemoral region. Treatment plan recommendations included medication modification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1%, 110gm, QTY: 3 tubes, with 6 refills: 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): page(s) 111-112.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Topical Analgesics. Recommended as an option as indicated below: 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. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren package insert. The requested medication is recommended for the use of neuropathic pain in the wrists per the California MTUS. The patient does subjectively report improvement in pain with the medication. However, the requested amount of the medication is in excess of recommendations. The requested amount equates to 11g/day. The maximum amount recommended for use in the upper extremities is 8g/joint/day. There is no indication in the documentation that the patient is using the medication in more places than the left wrist. Therefore the request does not meet recommendation guidelines and is not medically necessary.