MAXIMUS Federal Services

Case Number:	CM15-0108796		
Date Assigned:	06/15/2015	Date of Injury:	01/25/2010
Decision Date:	07/14/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/05/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 was a 56-year-old male, who sustained an industrial injury, January 25, 2010. The injured worker previously received the following treatments Dilaudid, Lidoderm Patches, Oxycontin, Neurontin, Aciphex, physical therapy and right S1 injection anterior 2 level lumbar fusion. The injured worker was diagnosed with lumbar spine degenerative disc disease and low back pain. According to progress note of April 6, 2015, the injured workers chief complaint was back pain radiating from the low back down the right leg. The injured worker rated the pain 6 out of 10 with pain medications and 10 out of 10 without pain medication. The injured worker denied any adverse effects from medications. The physical exam noted the injured worker to be in moderate pain. The injured worker was assisted by a wheelchair. The range of motion was restricted and not assessed due to postoperative status on March 2, 2015. There was a healed incision to the right posterior hip. The treatment plan included a prescription for Voltaren Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1%, Qty 5 with 3 refills, apply three times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Nonselective NSAIDS Page(s): 111, 107.

Decision rationale: Voltaren Gel (Diclofenac) is a non-steroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as lumbar spine pain and Knee pain. Therefore, request for Voltaren gel 1% with 3 refills is not medically necessary.