

Case Number:	CM15-0015502		
Date Assigned:	02/03/2015	Date of Injury:	01/13/2009
Decision Date:	03/30/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/27/2015

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, Washington

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:

The injured worker is a 54-year-old female who reported an injury on 01/13/2009. The mechanism of injury was not provided. The surgical history included left shoulder surgery with rotator cuff repair and post manipulation of the left shoulder. The injured worker underwent an MRI of the cervical spine and lumbar spine. The documentation of 01/05/2015 revealed the injured worker had complaints of increased low back pain with pain and numbness and tingling radiating into the left lower extremity and into her foot. The injured worker indicated the low back pain had been exacerbated with prolonged standing and walking, and with recent cold weather change. The injured worker had tenderness over the lumbosacral spine and over the bilateral lumbar paraspinal musculature where muscle spasms and myofascia trigger points were noted. The injured worker had increased low back pain on the extremes of extension in the lumbar spine. The diagnoses included herniated nucleus pulposus of the cervical spine and lumbar spine sprain/strain. The treatment plan included Voltaren gel 1% 100 g with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 100gms (use as directed with 3 refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. The clinical documentation submitted for review indicated the injured worker would utilize the medication. However, the body part that the medication would be used on was not noted. The treatment has not been evaluated for the treatment of the spine, hip, or shoulder. The request as submitted failed to indicate the body part to be treated with the Voltaren gel. There was a lack of documentation to support a necessity for 3 refills without re-evaluation, as this was noted to be a primary prescription. Given the above and the lack of documentation, the request for Voltaren gel 1% 100gms (use as directed with 3 refills) is not medically necessary.