

Case Number:	CM15-0018549		
Date Assigned:	02/06/2015	Date of Injury:	06/06/2013
Decision Date:	03/25/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/01/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 56 year old male who sustained an industrial injury on 06/08/13. He reports lower back pain radiating to the right buttock and calf. Diagnoses include musculoligamentous sprain/strain of the lumbar spine with right radiculopathy, degenerative disc disease, and right hip pain. Treatments to date include medications, physical therapy, chiropractic treatment, and a lumbar brace. In a progress note dated 01/12/15 the treating provider reports a treatment plan including Tramadol, diclofenac, and Voltaren gel. On 01/28/15 Utilization Review non-certified the Voltaren gel, citing MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 110 gm tubes #5 + 1 refill QTY: 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Pain, Compound creams

Decision rationale: Details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "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." MTUS specifically states for Voltaren Gel 1% (diclofenac) that 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." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment area would be for lumbar spine and hip. As such, the request for Voltaren Gel 1% tubes #5 + 1 refill QTY: 6.00 is not medically necessary.