

<b>Case Number:</b>	CM15-0018661		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	02/13/2006
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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

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 63 year old female, who sustained an industrial injury on 02/13/2006. She has reported subsequent back pain and was diagnosed with chronic lumbar discogenic pain, disc protrusion with annular tear and lumbar spine dysfunction. Treatment to date has included oral and topical pain medication and pain injections. In a progress note dated 12/18/2014, the injured worker complained of continued 5-7/10 back pain. Objective physical examination findings were notable for restricted range of motion of the lumbar spine, tenderness to palpation of the neural foramina L4-L5 and L5-S1, right gluteus medius, piriformis, SI joint and positive straight leg raising test on the right. A request for authorization of Voltaren gel and Lidocaine pad was made. On 01/07/2015, Utilization Review non-certified requests for Voltaren gel and Lidocaine pad noting that topical medications had not been proven with regards to overall efficacy and safety. MTUS and ODG guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% Day Supply: 30 Qty: 100 Refills: 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines,Pain Voltaren gel

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, the patient has documented symptomatic improvement from taking oral Advil, which is the preferred treatment. As such, the currently requested Voltaren gel is not medically necessary.

**Lidocaine Pad 5% Day Supply: 30 Qty: 30 Refills: 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 112.

**Decision rationale:** Regarding request for topical Lidocaine pad 5%, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed Lidoderm. Finally, there is no documentation of localized peripheral neuropathic pain as recommended by guidelines. As such, the currently requested Lidoderm is not medically necessary.