

Case Number:	CM15-0113435		
Date Assigned:	06/19/2015	Date of Injury:	08/19/2006
Decision Date:	07/20/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/12/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 62-year-old male, who sustained an industrial injury on 08/19/2006. He has reported injury to the low back. The diagnoses have included low back pain; aggravation versus exacerbation of symptomatic anterolisthesis L3-L4; and aggravation versus exacerbation of right L3 radiculopathy. Treatment to date has included medications, diagnostics, physical therapy, and home exercise program. Medications have included Tramadol, Gabapentin, Nabumetone, Soma, Norco, and Voltaren gel. A progress report from the treating physician, dated 05/13/2015, documented an evaluation with the injured worker. The injured worker reported an increase in low back pain following dumping a trash bag weighing about twenty pounds and twisting; constant aching pain in the center and to the right of the low back; also noted aching pain of the right thoracolumbar region; and he reports radiation of his back pain down his right lower extremity traveling anterolaterally. Objective findings included decreased lumbar spine range of motion; tenderness to palpation of the supraspinous ligament at T10-12 and L1-L3; tenderness to palpation of the right erector spinae; and positive Lasegue's sign. The treatment plan has included the request for Voltaren gel 15 #100g.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% #100g: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are 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. Voltaren gel is a topical analgesic. 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. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant did not have the above diagnoses and the claimant still required multiple opioids. There are diminishing effects after 2 weeks. The Voltaren gel is not medically necessary.