

Case Number:	CM15-0116734		
Date Assigned:	06/24/2015	Date of Injury:	12/13/1991
Decision Date:	07/23/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	06/16/2015

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 87 year old female, who sustained an industrial injury on 12/13/91. She reported pain in her lower back. The injured worker was diagnosed as having lumbar disc displacement, lumbar facet arthropathy, lumbar radiculopathy and chronic pain. Treatment to date has included an EMG/NCS on 7/30/12 showing chronic right L5-S1 radiculopathy and several lumbar MRIs. Current medications include Flexeril, Hydrocodone and Voltaren gel since at least 2/3/15. As of the PR2 dated 4/28/15, the injured worker reports lower back pain that radiates down the right lower extremity. She rates her pain a 3-6/10 with medications and a 6-8/10 without medications. Objective findings include limited lumbar range of motion due to pain and a positive straight leg raise test bilaterally. The treating physician requested Voltaren gel 1% 300gm #1 tube.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% 300gm 1 tube: Upheld

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

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 had been on the topical NSAIDs since at least December 2014 as well as other topical analgesics. The claimant is currently on oral analgesics without note in reduction of use with Voltaren. The claimant does not have the above diagnoses. There are diminishing effects after 2 weeks. The Voltaren gel is not medically necessary.