

Case Number:	CM15-0171264		
Date Assigned:	09/11/2015	Date of Injury:	08/03/2006
Decision Date:	10/15/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/31/2015

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

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 67 year old female, who sustained an industrial injury on August 3, 2006. She reported low back pain radiating to the left lower extremity. The injured worker was diagnosed as having lumbar degenerative disc disease. Treatment to date has included diagnostic studies, sacroiliac joint injection. Currently, the injured worker continues to report constant low back pain radiating intermittently to the left lower extremity and left ankle weakness. The injured worker reported an industrial injury in 2006, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on April 1, 2015, revealed continued pain as noted. It was noted thoracolumbar spine range of motion was "severely limited". It was noted she could forward flex 20 degrees and extend 5-10 degrees before stopping secondary to pain. Lateral bending was noted to be 5 degrees before the injured worker noted pain. She reported significant tenderness in the left sacroiliac joint. Straight leg test was noted as moderately positive on the left side and negative on the right side. She noted Norco was extremely helpful. She noted NSAIDs provided some improvement. She noted Diclofenac has been very helpful as well. It was noted she had an extremely complicated and serious condition in the spine with high grade stenosis, high grade spinal deformity and pronounced osteopenia which was noted to make her back inoperable. A sacroiliac joint injection using a spinal needle with administration of Marcaine, Decadron and Toradol was performed. The RFA included a request for Voltaren gel 1% and was non-certified on the utilization review (UR) on August 20, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter (Online Version).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents on 04/01/15 with lower back pain which radiates into the left lower extremity. The patient's date of injury is 08/03/06. Patient has no documented surgical history directed at this complaint. The request is for VOLTAREN GEL 1%. The RFA was not provided. Physical examination dated 04/01/15 reveals tenderness to palpation of the left SI joint, severely limited thoracolumbar range of motion, moderately positive straight leg raise test on the left, and trace weakness in the left ankle dorsiflexors. The patient is currently prescribed Norco, Omeprazole, and Diclofenac. Patient's current work status is not provided. MTUS Guidelines, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." This class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): 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." In regard to Voltaren gel for this patient's ongoing lower back pain with a radicular component, this medication is not supported for this patient's chief complaint. This patient presents with lower back pain which radiates into the left lower extremity. Guidelines do not support the use of topical NSAIDs such as Voltaren gel for spine, hip, or shoulder pain; as they are only supported for peripheral joint arthritis and tendinitis. Without evidence that this medication is being utilized for a peripheral complaint, the request cannot be substantiated. Therefore, the request IS NOT medically necessary.