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| Case Number: | CM15-0062396 | | |
| Date Assigned: | 04/08/2015 | Date of Injury: | 07/25/2008 |
| Decision Date: | 05/19/2015 | UR Denial Date: | 03/24/2015 |
| Priority: | Standard | Application Received: | 04/02/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 54 year old female, who sustained an industrial injury on 07/25/2008. According to a progress report dated 03/13/2015, the injured worker complained of low back pain with left rhythm right lower extremity symptoms, thoracic pain, left hip pain, cervical pain, right shoulder pain and left shoulder pain. Medications tried and failed included antiepileptic drugs and antidepressants. Successful trials included topicals. Diagnoses included protrusion L3-4 with bilateral foraminal stenosis, protrusion 4 millimeter at L5-S1 with bilateral foraminal stenosis, annular tear L5-S1, status post lumbar surgery 2009, thoracic pain, bilateral plantar fasciitis, cervical pain with upper extremity symptoms, right shoulder pain and thoracic pain. Treatment plan included continue with psychiatrist, Hydrocodone, Naproxen Sodium, Pantoprazole, and Cyclobenzaprine. Disability status was noted as permanent and stationary. Currently under review is the request for Voltaren Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% #300 with 4 refills (30 day supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

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

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further 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. As such, the request for Voltaren Gel 1% #300 with 4 refills (30-day supply) is not medically necessary.