

Case Number:	CM15-0086548		
Date Assigned:	05/08/2015	Date of Injury:	12/02/2013
Decision Date:	12/15/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	05/05/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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:

This is a 45 year old male who sustained an industrial injury on 12-2-2013. A review of the medical records indicates that the injured worker is undergoing treatment for mid back pain and low back pain. According to the progress report dated 4-4-2015, the injured worker complained of mid and low back pain. He rated his pain as 7 out of 10. He had been released to modified work, but was not currently working. Objective findings (4-4-2015) revealed an antalgic gait. He had tightness in his low back area with straight leg raise testing in sitting position. Treatment has included physical therapy, a home exercise program and medications. Current medications (4-4-2015) included Tylenol with Codeine and Galise. Past medications included Ibuprofen and Tramadol. The original Utilization Review (UR) (4-8-2015) denied a 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%: 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 Voltaren Gel; Diclofenac, topical.

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

Decision rationale: The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Voltaren (diclofenac) 1% gel is the medication and strength approved by the FDA. The submitted and reviewed documentation indicated the worker was experiencing mid- and lower back pain. There was no discussion detailing improved pain intensity or function with this medication or suggesting special circumstances that sufficiently supported this request. These records also reported the worker had been taking this medication for at least several months. Further, the request was for an indefinite supply, which would not account for changes in the worker's care needs. For this reason, the current request for Voltaren (diclofenac) 1% topical gel is not medically necessary.