MAXIMUS Federal Services

Case Number:	CM15-0093981		
Date Assigned:	05/20/2015	Date of Injury:	11/17/1997
Decision Date:	06/19/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/15/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 52-year-old female who sustained a work related injury November 17, 1997. According to a primary treating physician's report, dated May 1, 2015, the injured worker presented with complaints of mid-low back pain and left foot pain. The mid-low back pain is rated 5/10 and described as constant, sharp, and throbbing, radiating to the bilateral lower extremities, left greater than right, especially the knees. Left foot pain is rated 7/10 and described as constant, sharp pain and burning sensation in the heel, burning sensation in the bottom of the feet, occasional numbness/tingling, frequent swelling and occasionally radiates to the left knee with sharp pain. Diagnoses are fracture of left foot; left plantar fasciitis; lumbosacral joint ligament sprain/strain. Treatment plan included awaiting authorization for past requested massage therapy/pool therapy/thermal deep heat therapy, and at issue, a request for authorization 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% QTY 300: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (Diclofenac).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Nonselective Nsaids Page(s): 111, 107.

Decision rationale: Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment, guidelines section Topical Analgesics (page 111); topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as cervical spine pain, shoulder and knee pain. There is no evidence of osteoarthritis. Therefore, the request for Voltaren gel 1% is not medically necessary.