

Case Number:	CM15-0094197		
Date Assigned:	05/20/2015	Date of Injury:	12/01/1989
Decision Date:	06/22/2015	UR Denial Date:	05/07/2015
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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 57 year old male, who sustained an industrial injury on 12/01/1989. The medical records submitted for this review did not include the details of the initial injury or the prior treatments to date. Diagnoses include chronic nonmalignant pain of the lumbar spine and lumbosacral radiculopathy. Currently, he complained of chronic pain in the low back with radiation to bilateral lower extremities. Pain was rated 8/10 VAS. Current medications listed included Norco 7.5mg, Norflex, Voltaren, and Lidoderm patches. The medications were documented to help maintain functional capacity with no side effects reported. On 4/7/15, the physical examination documented muscle spasms and tenderness in the lumbar spine with decreased range of motion. There was decreased sensation noted in L4, L5 and S1 dermatomes bilaterally. The plan of care included continuation of medication therapy and a scheduled epidural steroid injection. The appeal request was for Voltaren Gel 1%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% 20 day supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Voltaren gel 1% 20 day supply is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Voltaren Gel 1% (diclofenac) 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. The documentation indicates the patient has spine pain and radiculopathy. Volteren gel is not indicated for the spine or for radiculopathy therefore this request is not medically necessary.