

<b>Case Number:</b>	CM13-0029901		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	07/09/2003
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation. Has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 67-year-old female who reported an injury on 07/09/2003. The mechanism of injury was not provided for review. The patient's most recent clinical evaluation dated 03/06/2014 documented that the patient had ongoing pain which did receive benefit from a topical cream. Physical findings included restricted flexion, extension and rotation of the neck. The patient's treatment plan included a refill of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PRESCRIPTION OF VOLTAREN GEL 1% 100G:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested prescription of Voltaren gel 1% "100G" is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient had significant cervical and shoulder pain complaints that are responsive to a topical cream. However, that topical medication is not clearly defined within the documentation. The

California Medical Treatment Utilization Schedule does not recommend the use of Voltaren gel 1% for spinal complaints. Additionally, the California Medical Treatment Utilization Schedule recommends a maximum dosage of 32 gm per day of Voltaren gel 1%. The request as it is submitted does not clearly indicate a dosage and frequency, duration of treatment or body parts that the medication should be applied to. Therefore, the appropriateness of this medication as it is written cannot be determined. As such, the requested Voltaren gel 1% 100 gm is not medically necessary or appropriate.