

<b>Case Number:</b>	CM13-0068696		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/01/1998
<b>Decision Date:</b>	05/23/2014	<b>UR Denial Date:</b>	11/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Florida. 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 injured worker is a 48-year-old male who reported an injury on July 1, 1998. The mechanism of injury was not stated. The current diagnosis is recurrent depressive psychiatric disorder. The injured worker was evaluated on November 4, 2013. The injured worker reported an increase in neck and lower back pain. Physical examination was not provided on that date. Mental status examination revealed irritability. Treatment recommendations included a prescription for Voltaren gel for topical pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN GEL 1% 100 GM, THREE COUNT WITH FOUR REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state the only FDA approved topical NSAID (non-steroidal anti-inflammatory drug) is Voltaren gel, which is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for the treatment of the spine, hip, or shoulder. Therefore, the current

request cannot be determined as medically appropriate. There was also no frequency listed in the current request. The request for voltaren gel 1% 100 gm, three count with four refills, is not medically necessary or appropriate.