

<b>Case Number:</b>	CM14-0138902		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/30/1998
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2014

### 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 Pain 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 injured worker is a 65-year-old who sustained an injury on September 30, 1998. The injured worker has been followed for ongoing chronic pain syndrome as well as low back pain. The injured worker has had an extensive prior history of narcotics use that has required several detox programs. The injured worker reported multiple falls in the past due to pain in the lower extremities. Prior medications had also included oral NSAIDs (non-steroidal anti-inflammatory drugs) and proton pump inhibitors. As of July 17, 2014 the injured worker's medications included Kadian, Percocet, and Clonidine. The injured worker's physical exam noted intact strength in the lower extremities with an antalgic gait. There was limited lumbar range of motion. The injured worker was recommended to use Voltaren Gel for the left hip. The requested Voltaren Gel was denied on July 25, 2014.

### 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 Treatment Guidelines.

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

**Decision rationale:** In regards to the use of Voltaren gel 1%, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. Voltaren gel can be considered as an option in the treatment of certain conditions, primarily osteoarthritis, when there is noted failure of standard NSAIDs (non-steroidal anti-inflammatory drugs) or indications that oral NSAID use is either not tolerated or contraindicated. It is noted that the injured worker previously utilized Naproxen with a proton pump inhibitor. There is no indication at this point that the injured worker is unable to utilize oral NSAIDs or has reasonably failed oral NSAIDs. Therefore, the request for Voltaren Gel 1% is not medically necessary or appropriate.