

<b>Case Number:</b>	CM14-0138261		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/16/2000
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 49-year-old female who has submitted a claim for lumbar degenerative disc disease, lumbar radiculopathy and shoulder pain associated with an industrial injury date of 9/16/2000. Medical records from 2014 were reviewed. The patient complained of low back pain, bilateral leg pain and right shoulder pain. The pain was rated 10/10 in severity and relieved to 6/10 with medications. She was also able to perform household chores with medications. Aggravating factors included standing, walking, bending, and lifting. She likewise complained of stomach upset, constipation, and incontinence. Physical examination showed positive straight leg raise test bilaterally, normal motor strength, intact reflexes, diminished sensation over the right L5 and S1 dermatomes and an antalgic gait with the use of a standard cane. Treatment to date has included acupuncture, physical therapy, heat modality, lumbar epidural injection, Norco, Fentanyl patch, Lunesta and Voltaren gel. The utilization review from 8/18/2014 denied the request for Voltaren gel 1%, #300 g because of no indication of extenuating clinical circumstance to support its use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% #300g:** Upheld

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

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

**Decision rationale:** As stated on pages 111-112 of CA MTUS Chronic Pain Medical Treatment Guidelines, topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Topical diclofenac is particularly indicated for osteoarthritis and tendinitis of the knee, elbow or other joints for short-term use (4-12 weeks). In this case, the patient complained of musculoskeletal shoulder pain rated 10/10 in severity and relieved to 6/10 with medications. She was also able to perform household chores with medication use. The patient complained of stomach upset from oral medication intake hence the prescription for a topical diclofenac formulation. The medical necessity has been established. However, the present request as submitted failed to indicate quantity to be dispensed. The request is incomplete; therefore, the request for Voltaren gel 1%, #300 g is not medically necessary.