

<b>Case Number:</b>	CM14-0186992		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	01/20/2011
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Anesthesia, has a subspecialty in Acupuncture & Pain Medicine and is licensed to practice in California. 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:

This case involves a 54 year old male injured worker with date of injury 1/20/11 with related abdominal, back, shoulder, and neck pain. Per progress report dated 10/3/14, the injured worker reported increased pain over the last few weeks, made worse with physical activity. He rated his back pain 6/10, and stated that it radiated into the right groin and down the inside of the right leg to the foot. He stated that any movement provoked the radiating pain. His right shoulder pain was constant and worsened with use of the extremity and neck pain was intermittent in the right side. Treatment to date has included surgery, physical therapy, medial branch block, TENS unit, and medication management. The date of UR decision was 10/10/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescription for Voltaren gel 2 gm with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** With regard to topical non-steroidal anti-inflammatory drugs (NSAIDs), MTUS states "These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks)." Voltaren Gel 1% specifically is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Per the guidelines, the indications of this medication are limited to joints that are amenable to topical treatment. The documentation submitted for review do not denote any indications for the request. Therefore, this request is not medically necessary.