

<b>Case Number:</b>	CM14-0208093		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	11/25/2010
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 is a 28 year old male who sustained a work related injury on 11/25/2010 when he was rear ended while driving which resulted in low back pain. Per the Primary Treating Physician's Progress Report dated 9/12/2014, the injured worker reported persistent low back and mid-thoracic pain, described as a 5-6 out of 10 in severity. The pain is described as achy and constant with radiation to the bilateral gluteal region and thighs. There is intermittent sharp, shooting pain. Pain is aggravated by standing, prolonged walking and bending. Objective physical examination revealed spasms in the lumbar paraspinal muscles and stiffness in the lumbar spine. There is tenderness noted in the lumbar facet joints bilaterally. There is some tenderness in the bilateral posterior superior iliac spine. Sensory is normal to light touch and strength is 5/5 in the bilateral lower extremities. Diagnoses include thoracic sprain/strain, lumbar sprain/strain, lumbar facet pain and possibility of lumbar radiculopathy. The plan of care includes medications including Voltaren gel. On 11/20/2014, Utilization Review non-certified a prescription for Voltaren gel based on lack of medical necessity. The CA MTUS Chronic Pain Medical Treatment Guidelines and ACOEM Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1 Percent 2 to 4 Grams:** 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:** The patient presents with pain affecting his lumbar spine. The current request is for Voltaren Gel 1 Percent 2 to 4 Grams. The treating physician states, Patient was given samples of Voltaren Gel for trial basis for pain and inflammation. (6) The MTUS Guidelines are specific that topical NSAIDS are, indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. MTUS does not support the usage of Voltaren cream for treatment of the spine or radicular pain. In this case, the treating physician has prescribed a topical analgesic for the lumbar spine that is not supported by the MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.