

<b>Case Number:</b>	CM15-0139518		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	10/15/2013
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

### 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 44 year old female, who sustained an industrial injury on 10-15-2013. She reported backwards extension while getting off a machine. The injured worker was diagnosed as having back pain, lumbar spondylosis, lumbosacral spondylosis without arthropathy, degeneration of lumbar intervertebral disc, myofascial pain syndrome, and myalgia and myositis, unspecified. Treatment to date has included diagnostics, physical therapy, lumbar facet joint injections, acupuncture, functional restoration program evaluation, and medications. On 3/19/2015, the injured worker complained of back pain, worse with extension and axial loading, along with numbness down the right thigh. Medications included Tylenol with codeine, Norco, and Voltaren gel. Currently, she complained of low back pain, right lower extremity pain, upper back pain, and right arm pain and numbness. She reported that "nothing has helped" in regards to her medical treatment thus far. She struggled with sleep and self care. She was currently not working modified duties. The current treatment plan included the continued use of Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POS Voltaren Gel 1% day supply: 25 #100 Rx Date: 6/11/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

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

**Decision rationale:** The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Voltaren (diclofenac) 1% gel is the medication and strength approved by the FDA. The submitted and reviewed documentation indicated the worker was experiencing pain lower and upper back regions, right leg, and right arm with numbness. This medication was to be used for areas not supported by the Guidelines. There was no discussion detailing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for 100 unspecified units (a 25-day supply) of Voltaren (diclofenac) 1% topical gel for the date of service 06/11/2015 is not medically necessary.