

<b>Case Number:</b>	CM15-0141234		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 46 year old female with an industrial injury dated 03/25/2014. Her diagnoses included closed head injury with concussion, cervical strain, left temporomandibular joint syndrome, and muscle contraction and vascular headaches. Prior treatment included physical therapy, acupuncture and medications. She presented on 06/01/2015 with complaints of pain in the back and stiffness when turning her head to the right. The provider documents the injured worker had found that the generic Gabapentin was ineffective when compared to the non-generic Neurontin three times a day that she was taking. Physical exam noted the injured worker was alert with normal mentation. Treatment plan included to continue Neurontin 100 mg three times a day without being given the generic medication. Voltaren gel was also recommended. She continued to work her usual and customary work activity; however she rated her pain level as 8/10. The request for Neurontin 100 mg # 90 was authorized. The treatment request for review is Voltaren Gel 1 % 100 gr tube quantity 1 with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% 100gr tube #1 with 2 refills:** Upheld

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

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

**Decision rationale:** Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). As this medication has not been evaluated for use in the spine or shoulder, the request is not supported. The request for Voltaren Gel 1% 100gr tube #1 with 2 refills is determined to not be medically necessary.