

<b>Case Number:</b>	CM15-0202908		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	03/01/2011
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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: Emergency 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 03-01-2011. A review of the medical records indicated that the injured worker is undergoing treatment for neuralgia. According to the treating physician's progress report on 06-04-2015, the injured worker continues to experience neck and thoracic pain radiating to the bilateral upper extremities, worse on the left side. Examination demonstrated left shoulder tenderness, decreased range of motion with limited strength in the left upper extremity due to pain. Muscle tone, deep tendon reflexes and sensation were intact in the bilateral upper extremities. The cervical area was tender to palpation at the trapezius, cervical and thoracic paraspinal muscles. Official report of an Electromyography (EMG) Nerve Conduction Velocity (NCV) of the bilateral upper extremities performed on 06-04-2015 was included in the review. Prior treatments, therapies and current medications were not included in the review. Treatment plan consists of the current request for topical Voltaren gel 1% 2mg tube. On 09-22-2015, the Utilization Review determined the request for topical Voltaren gel 1% 2mg tube was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medication-topical Voltaren Gel 1% 2 mg tube: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The requested medication, topical Voltaren Gel 1% 2 mg tube, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112, recommend topical analgesics with documented osteoarthritis with intolerance to oral anti-inflammatory agents. The injured worker has neck and thoracic pain radiating to the bilateral upper extremities, worse on the left side. Examination demonstrated left shoulder tenderness, decreased range of motion with limited strength in the left upper extremity due to pain. Muscle tone, deep tendon reflexes and sensation were intact in the bilateral upper extremities. The cervical area was tender to palpation at the trapezius, cervical and thoracic paraspinal muscles. The treating physician has not documented the patient's intolerance of these or similar medications to be taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Medication-topical Voltaren Gel 1% 2 mg tube is not medically necessary.