

<b>Case Number:</b>	CM15-0203630		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	05/01/1999
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 61 year old man sustained an industrial injury on 5-1-1999. Diagnoses include lumbar spine failed back syndrome. Treatment has included oral and topical medications, epidural steroid injections, surgical interventions, physical therapy, and acupuncture. Physician notes dated 8-3-2015 show complaints of back and bilateral upper extremity pain. The physical examination shows tenderness to palpation over the bilateral lumbar facet areas, negative straight leg raise, sensation and motor examinations are normal. Recommendations include Baclofen, Zanaflex, Neurontin, Fentanyl patch, Voltaren gel, Percocet, and follow up in four weeks. Utilization Review denied a request for Voltaren gel on 9-18-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% # 200:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, page 111-112, NSAIDs, states that Voltaren Gel is, 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). In this case there is insufficient evidence of osteoarthritis in the records from 8/3/15 to warrant Voltaren Gel. Therefore determination is not medically necessary.