

<b>Case Number:</b>	CM15-0208685		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	02/24/2010
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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: 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:

The injured worker is a 51 year old female, who sustained an industrial injury on 02-24-2010. Medical records indicated that the injured worker is undergoing treatment for chronic pain syndrome, displacement of cervical intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, sciatica, and myositis. Treatment and diagnostics to date has included physical therapy and medications. Recent medications have included Flector patches, Gabapentin, Tramadol, and Voltaren gel. Subjective data (06-17-2015 and 10-05-2015), included chronic neck, shoulder, upper back, right upper extremity, and lower back pain. Objective findings (10-05-2015) included tenderness over lumbar paraspinal muscles, limited lumbar range of motion, and positive right sided straight leg raise test. The Utilization Review with a decision date of 10-13-2015 non-certified the request for 3 tubes of Voltaren topical gel 1% 100 grams with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**3 tubes of Voltaren Topical Gel 1% 100 grams with 2 refills: Upheld**

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

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

**Decision rationale:** Per Guidelines, Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc.) for the acute first few weeks; however, it not recommended for non-joint disorders and if prescribed, long-term use beyond the initial few weeks of treatment. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID for this patient with non-joint osteoarthritis. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Clinical exam is without acute changes, progressive deterioration, or report of flare-up for this chronic 2010 injury. The 3 tubes of Voltaren Topical Gel 1% 100 grams with 2 refills is not medically necessary and appropriate.