

<b>Case Number:</b>	CM15-0056922		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	12/23/1999
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 65 year old male who sustained an industrial injury on 12/23/1999. Diagnoses include thoracic pain, thoracic degenerative disc disease, cervical pain, shoulder pain, cervical strain, cervical radiculopathy, and low back pain. Treatment to date has included diagnostic studies, epidural steroid injections, and medications. A physician progress note dated 03/04/2015 documents the injured worker complains of low back pain. He rates his pain with medications 8 on a scale of 1-10, and without medications as 10 on a scale of 1-10. His quality of sleep is poor. His activity remains the same. On examination he has a left sided antalgic gait. Lumbar spine range of motion is restricted. Lumbar facet loading is positive on both sides. Straight leg raising test is negative. The injured worker reported increased neuropathic pain to the left lower extremity that was so severe he went to the Emergency Department to rule out deep vein thrombosis. The treatment plan is for a trial of Voltaren gel and steroid injections were discussed. Treatment requested is for Voltaren 1% gel #3.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% gel #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NONSELECTIVE NSAIDS Page(s): 111, 107.

**Decision rationale:** Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as cervical spine pain, shoulder and knee pain. There is no evidence of osteoarthritis. Therefore request for Voltaren gel 1% #3 is not medically necessary.