

<b>Case Number:</b>	CM15-0082072		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	09/06/2012
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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 45-year-old female, who sustained an industrial injury on 09/06/2012. The initial complaints or symptoms included low back pain/injury. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x- rays, MRIs, CT scans, conservative therapies, injections, and lumbar spine surgery (06/18/2014). Currently, the injured worker complains of continued low back pain that was reported to be slightly improved with current medications of Norco and Ultram. The diagnoses include lumbar decompression and fusion. The request for authorization included Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% day supply 30 Qty 400; refills 00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** 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 long-term use beyond the initial few weeks of treatment as in this chronic injury. Submitted reports have not demonstrated significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID nor is there a contraindication to an oral NSAID use for this patient. The Voltaren Gel 1% day supply 30 Qty 400; refills 00 is not medically necessary and appropriate.