

<b>Case Number:</b>	CM14-0124362		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	08/21/2010
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 47-year-old male with 8/21/10 date of injury. At the time (6/11/14) of request for authorization for Voltaren 1% gel apply tid (3 times a day) #100; with 3 refills, there is documentation of subjective (low back pain radiating to bilateral feet) and objective (tenderness over the lumbar region and buttocks, decreased range of motion, and positive straight leg raising test) findings, current diagnoses (closed fracture of unspecified vertebra without spinal cord injury, myalgia and myositis not otherwise specified, osteoarthritis not otherwise specified unspecified site, and thoracic or lumbosacral neuritis or radiculitis not otherwise specified), and treatment to date (medications (including ongoing treatment with Voltaren gel since at least 11/13/13), physical therapy, and acupuncture). There is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks; failure of an oral NSAID or contraindications to oral NSAIDs; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% gel #100 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of closed fracture of unspecified vertebra without spinal cord injury, myalgia and myositis not otherwise specified, osteoarthrosis not otherwise specified unspecified site, and thoracic or lumbosacral neuritis or radiculitis not otherwise specified. In addition, there is documentation of ongoing treatment with Voltaren gel. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks). In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Therefore, based on guidelines and a review of the evidence, the request for Voltaren 1% gel #100 with 3 refills is not medically necessary and appropriate.