

<b>Case Number:</b>	CM14-0218724		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	02/19/2002
<b>Decision Date:</b>	03/04/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 is a 30-year-old male worker with a work related injury dated August 19, 2002. The documentation that was supported was for one date of service, August 21, 2014. In this documentation, the worker was complaining of tightness and stiffness. Pain was documented as reduced. This visit was an acupuncture visit and the worker received acupuncture, infrared therapy and electro acupuncture. A utilization review decision referenced a physician's visit dated September 24, 2014 in which the worker reported low back pain that was rated three to five on a scale of ten. The worker reported a flare-up of pain due to cold weather and increased use of home exercise program. Exam was documented as tenderness to palpation in the lumbar spine. Treatment plan at this visit was documented as TENS therapy, continued heat therapy, possible acupuncture, Omeprazole, Mentherm, Flexeril and Tramadol for moderate-to-severe pain. The actual documentation for this visit was not included with the documentation submitted for review. The utilization review decision dated December 4, 2014 non-certified the request for Voltaren gel one percent as not medically necessary. The CA MTUS guidelines reflected that the use of this medication was largely experimental with few randomized controlled trails to determine efficacy or safety. The primary recommended use is for neuropathic pain. Based on this documentation the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Volaten gel 1% #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

**Decision rationale:** According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is a topical analgesic. It 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. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant was given the gel for lumbar pain which lacks evidence for scientific evidence. In addition the length of prior and future treatments were not provided. The Voltaren gel is not medically necessary.