

<b>Case Number:</b>	CM15-0029315		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	07/12/2011
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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: 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:

The injured worker is a 30 year old male who sustained an industrial injury on 07/12/2011. Diagnoses include major depression, neck pain, lumbar disc displacement without myelopathy, tension headaches, pain in left shoulder and anxiety. Treatment to date has included medications, pain management, physical therapy, and Functional Restoration Program. A physician progress note dated 10/02/2014 documents the injured worker continue to report low back pain that radiates into his bilateral lower extremities. He has numbness and tingling in his lower extremities. He reports that some of his medication causes side effects of sedation so he does not use them and his other medications are not helping much. He has an antalgic gait. Straight leg raise is positive on the left and right. There is guarding and spasm in the lumber spine, significantly on the left side compared to the right side. Buprenorphine, cyclobenzaprine, and Gabapentin were discontinued. Treatment requested is for Retrospective Diclofenac Sodium 1.5% Gm DOS: 10/02/14. On 01/22/2015 Utilization Review non-certified the request for Retrospective Diclofenac Sodium 1.5% Gm DOS: 10/2/14 and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Diclofenac Sodium 1/5% Gm DOS: 10/2/14: 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 Page(s): 111-112.

**Decision rationale:** According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They 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. Diclofenac 1.5% is a topical NSAID. 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 had been on the gel for over a month. As noted above, its use for the back and shoulders has not been evaluated. Specifically, Voltaren has been more studied than Doiclofenac for the above diagnosis. The continued and long term use of topical Diclofenac is not medically necessary.