

<b>Case Number:</b>	CM15-0074055		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	01/14/2006
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 67 year old male who sustained a work related injury January 14, 2006. According to a primary treating physician's progress report dated March 19, 2015, the injured worker presented with complaints of back pain with a feeling of pain in his ankle, foot. There is low grade tenderness in the lower back and a positive straight leg raise. Diagnosis is documented as chronic lumbar dysfunction with radiculopathy. Treatment plan included active self-stretching and self-exercise and request for authorization of Flector patch.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flector patch #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines page 112. Diclofenac.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Topical Diclofenac. MTUS

guidelines state the following: 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. The patient currently lacks documentation of a diagnosis for osteoarthritis. He has been diagnosed with back pain. According to the clinical documentation provided and current MTUS guidelines; Topical Diclofenac is not indicated as a medical necessity to the patient at this time.