

<b>Case Number:</b>	CM15-0078640		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	08/05/2011
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 47 year old female, who sustained an industrial injury on 8/5/2011. The mechanism of injury is unknown. The injured worker was diagnosed as having multi-level spondylitic degenerative changes, status post left knee arthroscopy, left knee pain and lumbago. There is no record of a recent diagnostic study. Treatment to date has included surgery and medication management. In a progress note dated 4/10/2015, the injured worker complains of primarily mid and low back pain. The treating physician is requesting Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Prescription for Voltaren Gel 1% #3: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** 1 Prescription for Voltaren Gel 1% #3 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Voltaren Gel 1%

(diclofenac) 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. The documentation indicates that the patient has used this medication in the past, however there is no clear evidence of functional improvement on prior Voltaren Gel use. Furthermore, the request is not clear as to which body part this will be applied and the MTUS does not support topical Voltaren for the spine. Therefore, the request for Voltaren Gel and 3 refills is not medically necessary.