

<b>Case Number:</b>	CM14-0151898		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	07/17/2007
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Alabama. 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:

The patient is a 53 year old female who was injured on 07/17/2007 when she fell off a ladder. Prior treatment history has included Tylenol, Tramadol, Zanaflex and Voltaren gel, physical therapy and right hip injections. Orthopedic evaluation dated 07/21/2014, states the patient presented with complaints of neck, mid back and low back pain. She rated her pain as 3/10. On exam, cervical spine range of motion is 75% of full with pain. The thoracolumbar spine flexion is 75/90 degrees; extension is 20/25 degrees, and right and left lateral flexion is 25/25 degrees with negative toe walk and negative heel walk. The patient is diagnosed with cervical spine pain non-radicular, mid back pain, low back pain, and history of right hip greater trochanteric bursitis of a chronic nature. The patient was recommended to continue with Voltaren gel 1% 100gm with 2 refills. Prior utilization review dated 08/20/2014 states the request for Voltaren gel 1%, 100gm #3 with 2 refills is denied as there is no indication for this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1%, 100gm #3 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren gel Page(s): 113.

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

**Decision rationale:** The above MTUS guidelines for non-steroidal anti-inflammatory drugs (NSAIDs) topical analgesics states "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." In this case, there is no joint that lends itself to topical treatment indicated. Note from 7/21/14 reports diagnoses of cervical spine pain, mid back pain, low back pain, and right hip greater trochanteric bursitis. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.