

<b>Case Number:</b>	CM13-0009941		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	10/06/2002
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	08/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/16/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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 64-year-old female who reported injury on 10/06/2002. The mechanism of injury was not provided. The patient's current complaints were noted to be left shoulder pain, bilateral wrist and hand pain, low back pain, bilateral elbow pain, and right shoulder pain. The patient was noted to have bilateral range of motion deficits to the shoulders. The patient was noted to have decreased range of motion in the lumbar spine. The patient was noted to have a negative straight leg raise. The patient was noted to have tenderness over the dorsum and volar aspect of the wrists. The patient was noted to have a positive Phalen's bilaterally. The patient was noted to have tenderness in the right lateral elbow. The diagnoses were noted to include overuse syndrome of both upper extremities; left shoulder strain, status post 2 surgeries; bilateral wrist and hand tendinitis with bilateral carpal tunnel syndrome; bilateral elbow tendinitis; lumbar strain with coccygodyndia; and right shoulder strain. The request was made for Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%, 100gm tube:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren gel Page(s): 112.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS guidelines state that Voltaren® Gel 1% (diclofenac) is indicated for the 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). Clinical documentation submitted for review failed to provide the patient had documented osteoarthritis which would respond to Voltaren gel. There is a lack of documentation indicating the efficacy of the medication. Given the above, the request for Voltaren gel 1%, 100 gm tube is not medically necessary.

**Voltaren Gel 1%, 100gm tube x 2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren gel, Page(s): 112.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS guidelines state that Voltaren® Gel 1% (diclofenac) is indicated for the 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). Clinical documentation submitted for review failed to provide the patient had documented osteoarthritis which would respond to Voltaren gel. There is a lack of documentation indicating the efficacy of the medication. Given the above, the request for Voltaren gel 1%, 100 gm tube with 2 refills is not medically necessary.