

<b>Case Number:</b>	CM13-0020096		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	02/19/1996
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California 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 63-year-old female who reported an injury on February 19, 1996. The patient is currently diagnosed with bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release, status post anterior transposition and decompression, chronic cervical degenerative disc disease, impingement syndrome of the left shoulder, and chest pain secondary to costochondritis. The latest clinical note submitted is dated January 30, 2003 by [REDACTED]. The patient had resumed her usual and customary duties and had no increase in pain. Physical examination revealed surgical scars on bilateral upper extremities consistent with carpal tunnel release, full range of motion, minimal tenderness about the wrist, slight tenderness about the right elbow, and 60/65/70 grip testing on the right with 60/70/70 grip testing on the left. Treatment recommendations included continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% 500gm (Date of Service: 8/14/2013): Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs are recommended for osteoarthritis and tendonitis, and are recommended for a short duration to include 4 to 12 weeks. The only FDA approved topical NSAID includes diclofenac, which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. As per the clinical notes submitted, the patient does not maintain a diagnosis of osteoarthritis. Additionally, there is no documentation of a failure to respond to previous oral medications prior to the request for a topical analgesic. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.