

<b>Case Number:</b>	CM13-0059501		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/11/2011
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 34 year-old with a date of injury of 9/11/11. A progress report dated 10/24/13 identified subjective complaints of right wrist pain radiating into the upper extremity and left wrist pain from compensatory overuse. Objective findings included slightly decreased range-of-motion of the right wrist and mildly decreased sensation in the right palm. Motor function was normal. Diagnoses included right wrist triangular fibrocartilage complex (TFCC), right carpal tunnel syndrome, and left wrist and elbow pain. Treatment has included a right wrist TFCC repair in January 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN GEL:** 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 MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are recommended as an option in specific circumstances. However, they do state that they 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. Voltaren is an NSAID being used as a topical analgesic. The MTUS guidelines note that the efficacy of topical NSAIDs in clinical trials has been inconsistent and most studies are small and of short duration. Recommendations primarily relate to osteoarthritis where they have been shown to be superior to placebo during the first two weeks of treatment, but either not afterward, or with diminishing effect over another two week period. Guidelines also state that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. They are indicated for relief of osteoarthritis pain in joints that lend themselves to treatment (ankle, elbow, foot, hand, knee, and wrist). The Official Disability Guidelines (ODG) also do not recommend them for widespread musculoskeletal pain. In this case, there is no documentation of the failure of conventional therapy. Also, the strength and frequency were not specified. Therefore, the record does not document the medical necessity of Voltaren as an NSAID topical agent. The request is noncertified.