

Case Number:	CM14-0008034		
Date Assigned:	02/07/2014	Date of Injury:	01/22/2013
Decision Date:	07/24/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/17/2014

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 Occupational Medicine and is licensed to practice in California. 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 46-year-old male, who has submitted a claim for adhesive capsulitis of the shoulder, bursitis, tendinitis and partial rotator cuff tear; associated with an industrial injury dated January 22, 2013. Medical records from 2013 were reviewed, which showed that the patient complained of pain and discomfort involving his left shoulder, difficulties with overhead activities, difficulties with his activities of daily living (ADLs) and difficulty of sleeping at night due to pain. On physical examination of the left shoulder, well-healed arthroscopic portals were noted. MRI of the left shoulder, done on February 28, 2013 showed partial undersurface rotator cuff tear with mild-to-moderate AC joint degeneration. Treatment to date has included Hydrocodone, Diclofenac, Polar frost gel tube, Norco, Soma and left shoulder arthroscopy. The utilization review from December 26, 2013, denied the request for Voltaren Gel 1% 1 tube because it has not been evaluated for treatment of the spine, hip or shoulder. Likewise, it is not recommended as a first line treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN GEL 1% 1 TUBE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel. Decision based on Non-MTUS Citation Official Disability Guidelines, Voltaren Gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Topical Analgesics Page(s): 112.

Decision rationale: As stated on page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, Voltaren Gel was being prescribed with no supporting justification on the progress notes. The medical records also failed to provide evidence of osteoarthritis, which may warrant the use of Voltaren Gel. The patient did not present with gastrointestinal risk factors or intolerance to oral medications that may warrant use of topical analgesics. There is no clear indication for the use of this medication. Therefore, the request for Voltaren Gel 1% 1 Tube is not medically necessary.