

Case Number:	CM14-0170244		
Date Assigned:	10/20/2014	Date of Injury:	11/19/2010
Decision Date:	11/26/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/15/2014

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:

Patient is a 64 year-old male with date of injury 11/19/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/02/2014, lists subjective complaints as pain in the right shoulder. Patient is status post right shoulder arthroscopic surgery in 2011. Objective findings: Examination of the right shoulder revealed limited range of motion in all directions. He cannot raise his arm to touch the side of the head in full abduction or flexion either forward or sideways. No instability was noted. Right shoulder was locally tender with the possibility of a rupture of the longhead of the biceps tendon anteriorly. Spurling's test was negative. Patient had a strength deficit of 20% in the shoulders of the right shoulder as compared to the left. Sensation was normal. Diagnosis: 1. Tear of the rotator cuff at the right shoulder 2. Status post arthroscopic surgery with incomplete repair of the rotator cuff. The medical records supplied for review document that the patient was first prescribed the following medication on 09/02/2014. Medications; Voltaren Gel 1%, #1, apply two times a day.

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 Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren® Gel (diclofenac)

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with Diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Therefore, the Voltaren Gel 1%#1 tube is not medically necessary and appropriate.