

<b>Case Number:</b>	CM14-0056221		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	05/16/1997
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 58 year old female who had a work injury dated 5/16/97. The diagnoses include status post right fifth digit contusion; status post extensor tendon release; status post right carpal tunnel release; tenosynovitis. right middle and index finger. Under consideration are requests for Voltaren Gel 110 g with 2 Refills. There is a 2/16/14 progress note that states that the patient is back on follow-up. Since having last been seen, symptoms unchanged. Continues home exercise program. She is using her medications. On exam there is tenderness in the volar aspect of both wrists with diminished grip strength to 5-15. There is no laxity in either wrist. Negative Tinel's. Negative median compression test. Elbow shows tenderness at the lateral epicondyle with no crepitation. No laxity. The treatment plan includes a refill of meds including Voltaren gel, Celebrex, and Norco.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 110 g with 2 Refills:** Upheld

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

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

**Decision rationale:** Voltaren Gel 110 g with 2 Refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Voltaren Gel is indicated for 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. The guidelines also state that topical NSAIDS are recommended for short term use (4-12 weeks.) The documentation indicates that the patient has been using Voltaren Gel dating back to 12/6/13 already. The request for Voltaren Gel with 2 refills suggests that this is not being prescribed for the recommended short term use. Additionally the ODG states that Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, 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. The documentation does not indicate failure of oral first line NSAIDs. The request for Voltaren Gel is not medically necessary.