

<b>Case Number:</b>	CM14-0195645		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	11/10/2004
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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:

Injured worker is a male with date of injury 11/10/2004. Per primary treating physician's progress report dated 10/16/2014, the injured worker reports good pain control from current opioid pain medications. He reports increased physical activity, improvement in activities of daily living, mood, and sleep. His functional status is improved on medication compared to off medications. No aberrant behavior is observed. Diagnoses include 1) rotator cuff tendinitis, right greater than left 2) rotator cuff tear full thickness 3) right meralgia-paresthetica 4) T11 fracture with kyphotic deformity 5) arthritis at fracture site 6) GI distress 7) post-concussive head syndrome due to fall 8) depressed mood 9) scoliosis due to compression deformity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% 2 tubes with 3 refills:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to

placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The claims administrator reports in physician to physician communication that the injured worker has been utilizing Voltaren Gel 1% off and on for approximately 5 years. He utilizes Voltaren Gel 1% for flare ups only. Medical necessity of this request has been established within the recommendations of the MTUS Guidelines. The request for Voltaren gel 1% 2 tubes with 3 refills is determined to be medically necessary.