

<b>Case Number:</b>	CM15-0133015		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	06/30/2011
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 injured worker is a 34-year-old male, who sustained an industrial injury on 6/30/2011. The mechanism of injury was not described. The current diagnoses are left rotator cuff pathology and impingement, status post left arthroscopic subacromial decompression (1/22/2015). According to the progress report dated 1/23/2015, the injured worker complains of bilateral shoulder pain, left greater than right. In addition, he reports chronic back pain. The level of pain is not rated. The physical examination of the left shoulder reveals positive muscle spasms in his left upper trap, painful and slightly limited range of motion, and positive impingement sign. The current medications are Norco, Dilaudid, and Soma. It is unclear when the requested Voltaren gel was originally prescribed, and what body part it is to be applied. Treatment to date has included medication management. Work status was described as off work. A request for Voltaren gel has been submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% day supply; 30 qty; 200 refills; 00 Rx date 6/1/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Compound product Page(s): 111-113, 112.

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

**Decision rationale:** According to the California MTUS guidelines, Voltaren (Diclofenac) gel is a topical non-steroidal anti-inflammatory drug (NSAID) used for the treatment of osteoarthritis and tendonitis, in particular, knee and elbow joints that are amenable to topical treatment. There is little evidence that supports topical NSAIDs as a treatment option for spine and shoulder conditions. It may also be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. The duration of effect is for a short-term use (4-12 weeks) with reported diminished effectiveness over time. There is little evidence to use topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. The only FDA-approved topical NSAIDs are diclofenac formulations. All other topical NSAIDs are not FDA approved. The submitted documentation does not indicate that this injured worker had a diagnosis of osteoarthritis. In addition, the request for this medication included 200 refills, which is beyond recommended guidelines. Medical necessity for the requested topical gel has been not established. The requested 1% Voltaren gel is not medically necessary.