

Case Number:	CM15-0180675		
Date Assigned:	09/22/2015	Date of Injury:	08/25/2014
Decision Date:	11/02/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/14/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48 year old male who sustained an industrial injury on 8-25-14. He is back to work with some restrictions since 6-24-15. Diagnoses include repair of rotator cuff tear, right shoulder. He currently (8-5-15) complains of right shoulder pain with limited movement since returning to work. He ices his shoulder. His pain level was 2 out of 10 at rest and 7 out of 10 with activity, up from 1 out of 10 at rest and 4 out of 10 with activity prior to returning to work (6-24-15). On physical exam of the right shoulder there was noted atrophy and the shoulder has deteriorated with respect to his ability to raise his arm (prior to returning to work 150 degree raise and currently 30 degree raise) the result of the physical side of his job, decreased range of motion (unchanged form 6-24-15 note). The injured worker requested pain medication. Treatments to date include arthroscopic surgery to the right shoulder (2-20-15); physical therapy with benefit; weight lifting. In the progress note dated 8-5-15 the provider's plan of care included a request for Voltaren 1% Gel to be rubbed on the right shoulder. The request for authorization dated 8-21-15 indicated Voltaren gel 1%, 1 tube, apply to the right shoulder. On 8-28-15 utilization review evaluated and non-certified the request for Voltaren Gel 1% 1 tube based on the fact that topical analgesics are largely experimental and are recommended for neuropathic pain with little research to support their use. Any compounded product that contains at least one drug that is not recommended is not recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Based on the 8/5/15 progress report provided by the treating physician, this patient presents with right shoulder pain and low back pain, with pain rated 2/10 at rest and 7/10 with activity. The treater has asked for VOLTAREN GEL 1% TUBE on 8/5/15. The request for authorization was not included in provided reports. The patient states his right shoulder was "very sore, painful, and uncomfortable" after a whole days work, after being back at the job for a month per 8/5/15 report. The patient states he receives pain relief from icing shoulder per 8/5/15 report. The patient does not use any orthopedic appliances per 8/5/15 report. The patient is s/p unspecified number of physical therapy with good progress per 6/14/15 report. The patient is very motivated and is doing a home exercise program per 6/14/15 report. The patient has returned to modified work for a month per 8/5/15 report. MTUS Chronic Pain Medical Treatment Guidelines 2009, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. 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." "This class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): 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 treater is requesting Voltaren Gel on 8/5/15 "to be rubbed on the right shoulder." Review of the medical records provided did not indicate prior use; it appears that the treater is initiating this medication. The patient continues with pain in the right shoulder. MTUS guidelines state that "there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." Due to lack of support from MTUS guidelines, the requested Voltaren Gel IS NOT medically necessary.