

<b>Case Number:</b>	CM15-0188154		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	01/22/2011
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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 58 year old male, who sustained an industrial injury on 1-22-2011, from a fall approximately 15 feet with a closed head injury, facial laceration, rib fracture and left radius fracture. A review of the medical records indicates that the injured worker is undergoing treatment for left wrist fracture, left wrist sprain-strain injury, cervical myofascial pain syndrome, bilateral shoulder tendonitis, lumbosacral sprain-strain injury, left wrist surgery x2, right shoulder rotator cuff injury, lumbosacral disc injury, lumbosacral radiculopathy, bilateral rib fracture, and bilateral grade II spondylolisthesis due to L5 spondylosis. The Treating Physician's report dated 8-27-2015, noted the injured worker alert and oriented with no signs of sedation and a normal gait. The right shoulder was noted to have tenderness to palpation as well as painful range of motion (ROM) with abduction and flexion. The left wrist was noted to have tenderness to palpation as well as pain with range of motion (ROM). Prior treatments have included Functional Restoration Program, left wrist surgery in 2011, physical therapy, heat packs, lumbar corset, right shoulder subacromial cortisone injection, and medications including Medrol, Flexeril, Ibuprofen, Relafen, Omeprazole, Polar frost gel, Lidoderm patches, Tylenol, Terocin, Tramadol, Norco, Nortriptyline, and Neurontin. The treatment plan was noted to include continued use of the Voltaren gel for inflammation and pain control, prescribed since 4-9-2015, and Tramadol on an as needed basis for severe pain control in the spine, prescribed since 7-30- 2015, and use of a back brace to protect his low back. The request for authorization dated 8-27- 2015 requested Tramadol 50mg #30 and Voltaren gel. The Utilization Review (UR) dated 9-9- 2015, certified the Tramadol 50mg #30 and non-certified the Voltaren gel.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel:** 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:** The current request is for Voltaren Gel. The RFA is dated 08/27/15. Prior treatments have included Functional Restoration Program, left wrist surgery in 2011, physical therapy, heat packs, lumbar corset, right shoulder subacromial cortisone injection, and medications. The patient's work status was not addressed. 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." Per report 08/27/15, the patient presents with right shoulder, left wrist and lower back pain. The treater recommended a refill of medications, and a back brace. The patient has been using Voltaren gel for inflammation and pain control since 04/09/15. This patient presents shoulder, wrist and low back pain, and guidelines do not support the use of topical NSAIDs such as Voltaren gel for spine, hip, or shoulder pain. While this patient presents with complaints in the left wrist, the provider does not specify that this gel is intended for the wrist. Without evidence that this medication is being utilized for a peripheral complaint, the request cannot be support. Furthermore, the patient has been using this topical gel since 04/09/15 with no discussion regarding efficacy. MTUS page 60 requires recording of pain and function when medications are used for chronic pain. Therefore, the request is not medically necessary.