

<b>Case Number:</b>	CM15-0027528		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	12/16/2011
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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 62 year old, female patient, who sustained an industrial injury on 12/16/2011. A follow up visit dated 01/06/2015, reported present complaint of neck pain, bilateral shoulder pain, and bilateral wrist/hand pain. The patient last worked on 01/05/2015. Roentgenograms taken that day, showed cervical spine with multi-level degenerative disc disease, degenerative osteoarthritis more so at C5-6 and C6-7; no compression fracture or listhesis. Shoulders with acromioclavicular joint degeneration osteoarthritis. The wrist/hands also with mild degenerative osteoarthritis. She is diagnosed with cervicalgia; joint pain, shoulder; adhesive capsulitis, shoulder; joint pain forearm; hand arthralgia and hand/wrist bursitis. A request was made for medication Voltaren Gel 1%, 2 tubes. On 12/22/2015, Utilization Review, non-certified the request, noting the CA MTUS, Chronic Pain, Topical Analgesia was cited. The injured worker submitted an application for independent medical review of requested services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Voltaren Gel 1% number three (#3) tubes:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc..) for the acute first few weeks; however, it not recommended for long-term use beyond the initial few weeks of treatment as in this chronic injury. Submitted reports have not demonstrated significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID nor is there a contraindication to an oral NSAID use for this patient. The Purchase of Voltaren Gel 1% number three (#3) tubes is not medically necessary and appropriate.