

<b>Case Number:</b>	CM15-0027738		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/27/2015
<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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 37 year old female who sustained an industrial injury on 05/01/2014. Diagnoses include shoulder arthralgia, wrist arthralgia, cervicgia, and wrist sprain/strain. Treatment to date has included medications, heat, ice, home exercise program, bilateral wrist splints, and physical therapy. A physician progress note dated 12/23/2014 documents the injured worker has tenderness in her cervical spine, shoulders, wrists and hands. Range of motion is decreased in her shoulders. Treatment requested is for Voltaren Gel 1%. On 01/27/2015 Utilization Review non-certified the request for Voltaren Gel 1% and cited was Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Voltaren

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

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Voltaren (Diclofenac) gel 1% one gel tube is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The only available FDA approved topical analgesic is diclofenac. However, diclofenac gel is indicated for relief of osteoarthritis pain in the joint that lends itself the topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the injured worker's working diagnoses are shoulder arthralgia; wrist arthralgia; cervicalgia; and wrist sprain-strain. Subjectively, there were no complaints noted in the December 23, 2014 progress note. Diclofenac gel is indicated for relief of osteoarthritis pain in the joint that lends itself to topical treatment. The treating physician did not document osteoarthritis or osteoarthritis related pain in a joint that lends itself to topical treatment. Consequently, absent clinical documentation supporting indications recommended by the guidelines, Voltaren (Diclofenac) gel 1% one gel tube is not medically necessary.