

Case Number:	CM14-0166464		
Date Assigned:	10/13/2014	Date of Injury:	02/13/2001
Decision Date:	11/13/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/09/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 (IW) is a 69-year-old man who was injured February 13, 2001. Records indicated multiple injuries to the shoulder, arms, thumb, and cervical spine after a fall. The original diagnoses the original diagnoses from November 12, 2001 visit our cervical spondylosis with radicular symptoms; bilateral shoulder impingement syndrome; bilateral medial and lateral epicondylitis/forearm myofasciitis; and carpal tunnel syndrome, right worse than left with a normal nerve conduction study. The current clinical assessment as of September 2, 2014 describes left hip trochanteric bursitis, chronic in nature being treated for "several years". Physical examination showed tenderness on palpation of the trochanteric bursa and painless range of motion on the left hip and tightness at the IT band. Recommendation was for Voltaren Gel and a course of formal physical therapy for 12 additional sessions. There is documentation of prior physical therapy and use of medications as well as topicals in this case. There is no documentation of clinical imaging or other forms of treatment noted.

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: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Topical Analgesics Page(s): 111-113.

Decision rationale: Pursuant to the California MTUS chronic pain medical treatment guidelines, Voltaren gel is not medically necessary. The guidelines recommend Voltaren gel as an option in specific circumstances; however, studies for its use are largely experimental with few randomized controlled trials to determine efficacy and safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, after drug interactions, and no need to titrate. There is little to no research; however, to support the use of many of these agents. These agents require knowledge of the specific analgesic effect of each agent and how it will be used for the specific therapeutic goal required. Although FDA approved, Voltaren is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been approved for treatment of the spine, hip or shoulder. In this case, the guidelines would not support the use of Voltaren gel. Voltaren gel is typically recommended in the topical setting for osteoarthritis in joints that lend themselves to topical treatment. It is not indicated for treatment and use of the spine, hip and shoulder. Consequently, the use of Voltaren gel is not indicated for use over the left hip and trochanteric bursa. Based on the clinical documentation the evidence, peer-reviewed based guidelines, Voltaren gel is not medically necessary.