MAXIMUS Federal Services

Case Number:	CM14-0217074		
Date Assigned:	01/06/2015	Date of Injury:	12/30/2013
Decision Date:	02/28/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 39 year old female with a date of injury of 12-30-2013. She was moving boxes when she felt a pop to her left shoulder. She has had pain on a 7-8/10 level to the left shoulder without neurologic complaints. An MRI scan of the shoulder revealed evidence of a partial supraspinatous tendon tear and subacromial and subdeltoid bursitis. She had been treated with extensive physical therapy and oral anti-inflammatories. Cortisone injections have been given on two occasions. She was deemed a potential candidate for arthroscopic surgery but she has chosen instead to continue with physical therapy. The left shoulder physical examination reveals markedly diminished range of motion in nearly all planes, positive impingement findings, and tenderness of the rotator cuff region, the left bicipital groove, and left trapezius. At issue is a request for Voltaren gel 1% with 2 refills. This was previously non-certified based on MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. FDA-approved agents: 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. Maximum dose should not exceed 32 g perday (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltarenpackage insert).In this instance, the intended application site for the Voltaren gel is the left shoulder. Because Voltaren gel has not been evaluated for the treatment of the shoulder, Voltaren gel 1% with 2 refills is not medically necessary in accord with the referenced guidelines.