

Case Number:	CM15-0118050		
Date Assigned:	06/26/2015	Date of Injury:	06/04/2008
Decision Date:	07/28/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/18/2015

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: Preventive Medicine, Occupational 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 52 year old female, who sustained an industrial injury on 6/4/2008. She reported upper extremity pain. Diagnoses have included right shoulder adhesive capsulitis, right shoulder pain, right lateral and medial epicondylitis, right ulnar neuritis and left wrist and hand pain. Treatment has included physical therapy and medication. According to the progress report dated 5/5/2015, the injured worker complained of persistent right elbow, right wrist and right shoulder pain. She reported that Ibuprofen made her drowsy and the Voltaren Gel was not strong enough. Objective findings revealed tenderness at the right medial and lateral epicondylar region. Dysesthesia was noted to light touch in the right ulnar nerve distribution and in the right C6, C7 and C8 dermatomes. There was tenderness in the right acromioclavicular joint. Authorization was requested for Voltaren Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 400gm: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Voltaren® Gel (diclofenac).

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Voltaren Gel 1% 400gm is not medically necessary.