

<b>Case Number:</b>	CM14-0185400		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	05/15/2007
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient is a 64 year old female with an injury date on 05/15/2007. Based on the 10/28/2014 progress report provided by the treating physician, the diagnoses are: complex regional pain syndrome and shoulder-hand syndrome. According to this report, the patient complains of 7-8/10 sharp stabbing bilateral shoulder and forearm pain. Pain interfere patient level of function, including lifting and carrying. Physical exam of the left hand and forearm reveals mild atrophy and pale in color compared to right. There were no other significant findings noted on this report. The utilization review denied the request on 11/04/2014. The requesting provider provided treatment reports from 05/16/2014 to 10/28/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% topical gel 100gm with 1 refill:** 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 Page(s): 111-113.

**Decision rationale:** According to the 10/28/2014 report, this patient presents with 7-8/10 sharp stabbing bilateral shoulder and forearm pain. The provider is requesting Voltaren 1% topical gel

100gm with 1 refill. Regarding Voltaren gel, MTUS guidelines states "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." In this case, the patient does not meet the indication for the topical medication as she does not present with a diagnosis for peripheral joint arthritis. The patient does present with forearm pain, but the provider does not indicate how this topical is being used and with what efficacy. Therefore, the requested medication is not medically necessary and appropriate.