

<b>Case Number:</b>	CM15-0002306		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	05/24/2012
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 60-year-old female who reported an injury on 05/24/2012. The mechanism of injury was not stated. The current diagnoses include status post rotator cuff surgery of the left shoulder, adhesive capsulitis of the right shoulder, and rotator cuff tendinosis of the right shoulder. The current medication regimen includes Voltaren gel 1%. The injured worker presented on 12/09/2014 with complaints of persistent shoulder pain with repetitive motion and overhead activity. Upon examination, there was diminished grip strength, tenderness to palpation, diminished range of motion of the right shoulder, and normal range of motion of the left shoulder. Recommendations included a prescription for Voltaren gel 1%. It was noted that the injured worker had failed oral NSAIDs. A Request for Authorization form was then submitted on 12/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% 180grams with 1 refill Between 12/9/2014 and 1/31/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

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

**Decision rationale:** California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac gel 1%, which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the spine, hip, or shoulder. There is also no frequency listed in the request. Therefore, the current request cannot be determined as medically appropriate in this case.