

<b>Case Number:</b>	CM15-0106841		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	12/20/2013
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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: Physical Medicine & Rehabilitation

### 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 45-year-old male who sustained an industrial injury on 12/20/13. The injured worker was diagnosed as having left shoulder strain, left shoulder supraspinatus tendon tear and left shoulder adhesive capsulitis. Currently, the injured worker was with complaints of left shoulder discomfort. Previous treatments included physical therapy, home exercise program, and medication management. Physical examination was notable for tenderness over the left anterior glenohumeral surgical scar, trapezius and deltoid region with limited range of motion. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% quantity 100:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren gel (diclofenac). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** Per Guidelines, Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc...) for the acute first few weeks, not demonstrated here. It is not recommended for long-term use beyond the initial few weeks of treatment for this chronic injury. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Recent report noted chronic pain symptoms with unchanged activity level. Clinical exam is without acute changes or report of flare-up for this chronic injury. The Voltaren gel 1% quantity 100 is not medically necessary and appropriate.