

<b>Case Number:</b>	CM15-0016334		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	05/19/2012
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	01/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 28 year old male, who sustained an industrial injury on 5/19/2012. The diagnoses have included disorder of bursa of shoulder region and cervicgia. Treatment to date has included medication. According to the progress note dated 1/8/2015, the injured worker complained of pain in the right shoulder and neck. The injured worker reported increasing right shoulder pain over the past three or four months. Physical exam revealed good range of motion of the right shoulder with periodic clicking. Physician discussion noted that the injured worker's right shoulder pain had improved somewhat but remained symptomatic with exercise. Physical therapy had been denied. Voltaren gel was recommended. On 1/17/2015 Utilization Review (UR) non-certified a request for Voltaren 1% #1 100gm tubes Refill: 2. The Medical Treatment Utilization Schedule (MTUS) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1%, #1 100mg tube with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

**Decision rationale:** The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Diclofenac 1% is the medication and strength approved by the FDA. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and right shoulder. There was no discussion detailing improved pain intensity or function with this medication or suggesting special circumstances that sufficiently supported this request. Further, these records indicated the worker had been taking this medication for at least several months. For these reasons, the current request for a 100mg tube of Voltaren (diclofenac) 1% with two refills is not medically necessary.