

<b>Case Number:</b>	CM15-0022392		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	05/13/2011
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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, Arizona  
 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 60-year-old female who reported an injury on 05/13/2011. The mechanism of injury was not stated. The current diagnoses include right 3rd, 4th, and 5th digit tenosynovitis; right 3rd digit trigger finger; possible complex regional pain syndrome of the right foot; possible complex regional pain syndrome of the right wrist/hand; depression associated with chronic pain; and status post right shoulder rotator cuff repair on 08/29/2013. The injured worker presented on 12/12/2014 for a follow-up evaluation with complaints of persistent right upper extremity pain as well as neck pain. The injured worker was awaiting authorization for a cervical spine injection. The current medication regimen includes Lidoderm patch, Flector gel, and Norco. Upon examination, there was tenderness at the right shoulder AC more than glenohumeral, decreased range of motion of the right shoulder, 120 degree abduction with associated pain, tenderness of the right hand 3rd and 4th digits, and tenderness at the right wrist joints. Recommendations included continuation of the current medication regimen. The injured worker was also issued a prescription for Voltaren 1% gel. A Request for Authorization form was submitted on 12/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The California MTUS Guidelines state the only FDA approved topical NSAID is Voltaren gel 1%, which is indicated for the relief of osteoarthritis pain. In this case, the injured worker does not maintain a diagnosis of osteoarthritis. The request as submitted also failed to indicate a frequency and quantity. Therefore, the request is not medically appropriate at this time.