

Case Number:	CM14-0005157		
Date Assigned:	01/24/2014	Date of Injury:	10/01/2012
Decision Date:	06/11/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/14/2014

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, and is licensed to practice in Illinois. 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 injured worker is a 64-year-old who reported an injury on October 1, 2012. The mechanism of injury was a lifting injury. According to the clinical note dated December 28, 2013 the injured worker reported pain to the right shoulder rated a 9/10, described as intermittent and radiating proximally to his neck, upper back, and right arm. He also reports numbness, tingling, cramping, burning, throbbing, stabbing, aching, dull, and sharp sensations. On physical exam it was noted the injured worker had decreased range of motion with pain, tenderness to the AC joint, and a positive popeye sign to right biceps. The diagnoses for the injured worker included right irreparable rotator cuff tear, right shoulder anterior impingement syndrome, osteoarthritis of the right AC joint, and severe degeneration of the right biceps tendon. According to the operative report dated October 24, 2013, the injured worker underwent diagnostic arthroscopy of the right shoulder, resection of the right distal clavicle, open right acromioplasty, and resection of the right coracoacromial ligament. The request for authorization for medical treatment was not provided in the clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

THREE (3) VOLTAREN GEL 1% 100 MG. APPLY 2-4G TO AFFECTED AREA QID ONCE A MONTH FOR SYMPTOMS RELATED TO RIGHT SHOULDER INJURY:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman & Gilman's The Pharmacological Basis of Therapeutics, 12th Edition Mcgraw Hill, 2006.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

Decision rationale: The Chronic Pain Medical Treatment Guidelines notes that Voltaren gel is 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. The provided documentation reported the injured worker had osteoarthritis of the right AC joint; this medication has not been evaluated for application to the shoulder. It did not appear the injured worker had a diagnosis for which Voltaren gel would be indicated. The request for three Voltaren gel 1% 100 mg, apply two to four grams to affected area four times daily once a month for symptoms related to right shoulder injury, is not medically necessary or appropriate.