

Case Number:	CM14-0115777		
Date Assigned:	08/04/2014	Date of Injury:	10/27/2006
Decision Date:	09/22/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/23/2014

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 Occupational Medicine and is licensed to practice in California. 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:

According to the records made available for review, this is a 56-year-old female with a 10/27/06 date of injury, and status post left shoulder subacromial decompression, distal clavicle resection, and arthroscopic rotator cuff repair 1/21/14. At the time (6/23/14) of request for authorization for Outpatient post-operative physical therapy, 2 times a week for 6 weeks for the left shoulder and Voltaren gel cream, there is documentation of subjective (left shoulder pain, tightness, swelling, and limited range of motion, trouble dressing herself, not able to reach back, using right arm for assistance, right arm feels numb especially at night and in morning, patient feels she needs more physical therapy as her arm is still weak and has limited range of motion, and left ankle still having pain and swelling and feeling like it gives out) and objective (left shoulder active range of motion: flexion/abduction to 130 degrees, external rotation 90, internal rotation 70 degrees, left shoulder passive range of motion: flexion/abduction to 160 degrees, external rotation 90, internal rotation 80, tenderness and swelling at Achilles tendon with thickening, consistent with irregular healing, and no change in range of motion) findings. The current diagnoses are shoulder acromioclavicular joint arthritis, joint pain-shoulder, wrist arthralgia, hip arthralgia, joint pain-ankle, cervical herniated nucleus pulposus, shoulder impingement/bursitis, shoulder sprain/strain rotator cuff, sprain/strain hip and/or thigh, and sprain of ankle. The treatment to date includes physical therapy, surgery, and medications (including Norco, Pravastatin, Prilosec, and Tramadol). 6/3/14 medical report identifies patient has completed 32/36 physical therapy sessions. Regarding Voltaren gel cream, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment, the intention to treat over a short course, and failure of an oral NSAID or contraindications to oral NSAIDs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient post-operative physical therapy, 2 times a week for 6 weeks for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of shoulder acromioclavicular joint arthritis, joint pain-shoulder, wrist arthralgia, hip arthralgia, joint pain-ankle, cervical herniated nucleus pulposus, shoulder impingement/bursitis, shoulder sprain/strain rotator cuff, sprain/strain hip and/or thigh, and sprain of ankle. In addition, there is documentation of status post left shoulder subacromial decompression, distal clavicle resection, and arthroscopic rotator cuff repair on 1/21/14 and at least 32 sessions of post-operative physical therapy sessions completed to date, which exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for Outpatient post-operative physical therapy, 2 times a week for 6 weeks for the left shoulder is not medically necessary.

Voltaren gel cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Anti-inflammatory creams.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel 1%. In addition, MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications or medical services. The Official Disability Guidelines identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of a diagnosis of shoulder acromioclavicular joint arthritis, joint pain-shoulder, wrist arthralgia, hip arthralgia, joint pain-ankle, cervical herniated nucleus pulposus, shoulder impingement/bursitis, shoulder sprain/strain rotator cuff, sprain/strain hip and/or thigh, and sprain of ankle. However, despite documentation of subjective (left ankle still having pain and swelling and feeling like it gives out) and objective (tenderness and swelling at Achilles tendon with thickening, consistent with irregular healing, and no change in range of motion) findings, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle). In addition, there is no documentation of the intention to treat over a short course (4-12 weeks). Furthermore, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Therefore, based on guidelines and a review of the evidence, the request for Voltaren gel cream is not medically necessary.