

Case Number:	CM14-0146625		
Date Assigned:	09/12/2014	Date of Injury:	02/02/2009
Decision Date:	11/05/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/09/2014

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 Orthopedic Surgery and is licensed to practice in Texas. 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 69-year-old male who reported an injury on 02/02/2009. The mechanism of injury was not provided. The injured worker's diagnoses included right rotator cuff tear and left shoulder pain. Past medical treatment included physical therapy, medications and surgery. Diagnostic testing was not provided. The injured worker underwent arthroscopic subacromial decompression and mini open rotator cuff repair on 07/12/2005 and he had a re-tear of right rotator cuff and had arthroscopic extensive debridement, removal of 2 screws/suture anchors, subacromial decompression and rotator cuff repair from new tear on 05/05/2009. The injured worker complained of increased pain to the left shoulder and right shoulder pain on 04/22/2014. The right shoulder pain was worse than the left. He rated his right shoulder pain 10/10 without pain medications and 6/10 with pain medications. The physical examination revealed limited active range of motion of the right shoulder joint, manual muscle testing was deferred on the right upper extremity due to patient's increased pain. The left shoulder active range of motion revealed flexion 0 degrees to 120 degrees, abduction 0 degrees to 90 degrees, extension 0 degrees to 40 degrees. Medications included Norco 10/325 and Voltaren gel. The treatment plan included Voltaren 300 g and physical therapy #10 for the left shoulder. The rationale for the request was not submitted. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 300g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren 300 is not medically necessary. The injured worker complained of increased pain to the left shoulder and right shoulder pain on 04/22/2014. The California MTUS guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. The injured worker has right shoulder pain complaints. There is a lack of documentation which indicates the injured worker has osteoarthritis or tendinitis to a joint amenable to topical treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Therefore the request for Voltaren 300g is not medically necessary.

Physical therapy #10 for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 99, Chronic Pain Treatment Guidelines Diclofenac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for physical therapy #10 for left shoulder is not medically necessary. The California MTUS guidelines recommend allowing for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus participation in an active self-directed home physical medicine program. The guidelines recommend 9-10 sessions of physical therapy over 8 weeks. There is a lack of documentation indicating the total number of sessions of physical therapy the injured worker has completed. There is a lack of documentation of initial or interim evaluations to determine the injured worker's progress. There is a lack of documentation indicating the injured worker is compliant with participation in a home exercise program. Therefore the request for physical therapy #10 for left shoulder is not medically necessary.