

Case Number:	CM14-0169086		
Date Assigned:	10/17/2014	Date of Injury:	11/12/2012
Decision Date:	11/19/2014	UR Denial Date:	10/04/2014
Priority:	Standard	Application Received:	10/14/2014

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 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:

The injured worker is a 38-year-old male with a date of injury on 11/12/2012. As per 8/28/14 report, he presented with 8/10 severity of the left shoulder pain. An examination revealed 3 well healed surgical incisions over the lateral aspect of the shoulder, normal range of motion of the left shoulder, primary pain in the biceps tendon, deltoid musculature weakness and spasms, and decreased sensation to palpation over the left acromioclavicular (AC) joint. X-ray of the left shoulder dated 12/12/13 revealed probable postsurgical changes from resection of the distal left clavicle simulating acromioclavicular separation. Magnetic resonance imaging (MRI) of the left shoulder dated 1/4/13 revealed mild supraspinatus tendinosis without a focal rotator cuff tear and mild acromioclavicular arthrosis with inferior osseous prominence which comes in close proximity to the supraspinatus myotendinous junction. He is status post left shoulder arthroscopy dated 7/25/13 and had completed 24 post-operative physical therapy sessions. He is currently on Tramadol, Ibuprofen and Tizanidine. Recent urine point of care (POC) testing dated 7/25/14 was negative. Currently he was prescribed Voltaren gel, Tramadol, Ibuprofen and Tizanidine. No specific benefits with the medications were documented. Diagnoses include status post left shoulder arthroscopy. The requests for Voltaren 1% gel #30 100mg with 1 refill and Ibuprofen 800mg #60 with 1 refill were denied on 10/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Voltaren 1% gel #30 100mg with 1 refill: 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 Topical analgesics Page(s): 111.

Decision rationale: Per California Medical Treatment Utilization Schedule (MTUS) guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the 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. It is recommended for osteoarthritis after failure of oral non-steroidal anti-inflammatory drugs (NSAIDs), or in the case of contraindications to oral NSAIDs, or for injured workers who cannot swallow solid oral dosage forms. In this case, there is no diagnosis of osteoarthritis in the medical records and there is no evidence of prior failure of oral NSAIDs. Furthermore, there is little to no documentation of any significant improvement in pain level (i.e. visual analog scale [VAS]) or function with prior use. Therefore, the request is not medically necessary.

One prescription of Ibuprofen 800mg #60 with 1 refill: 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: According to the Medical Treatment Utilization Schedule (MTUS), non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as Acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and Acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. Long-term use of NSAIDs is not recommended as there is no evidence of long-term effectiveness for pain or function. In this case, there is little to no documentation of any significant improvement in pain level (i.e. Visual Analog Scale [VAS]) or function with continuous use. Long-term use of NSAIDs at high dose is not recommended due to gastrointestinal (GI) and renal side effects. In the absence of objective functional improvement, the medical necessity for Ibuprofen has not been established.