

Case Number:	CM14-0034590		
Date Assigned:	06/20/2014	Date of Injury:	01/04/2010
Decision Date:	07/18/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/20/2014

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 Orthopaedic Surgery 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:

This 56-year-old female typist clerk sustained an industrial injury on 1/4/10, due to repetitive lifting and moving file boxes. Past medical history was positive for cervical multilevel degenerative disc disease with C5/6 radiculopathy. She underwent right shoulder arthroscopic subacromial decompression, acromioplasty with Mumford procedure, and debridement of the labrum and a partial rotator cuff tear on 9/18/13. The 2/17/14 treating physician report indicated the patient was doing well clinically. Subjective complaints included shoulder girdle pain with some residual swelling and pain radiating down the right hand with associated numbness and tingling. Physical exam documented right shoulder flexion/abduction 0-155, internal rotation to L3, and manual muscle testing 4/5. The patient was to complete 8 recently approved physical therapy visits. Additional physical therapy 2x6 was recommended for work hardening. She was unable to do her job without restriction and was having difficulty with overhead activity. A spinal Q brace was recommended for scapular stabilization and postural deficits. The 3/3/14 utilization review denied the request for physical therapy for work hardening as the patient had not completed all her authorized physical therapy and was not indicated to have plateaued nor was a functional capacity evaluation performed. The scapular stabilization brace was denied as there was no evidence of need for stabilization or posture modification, and prolonged use of a sling for symptom control was not recommended. The request for Voltaren gel was denied as treatment guidelines do not recommend use in the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks (12) sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, Work Hardening Page(s): 125-126.

Decision rationale: Under consideration is a request for physical therapy 2 times a week for 6 weeks (12) sessions. The provider has indicated that work hardening was intended. The California MTUS recommends work hardening programs as an option and provide specific criteria for admission. Admission criteria includes: work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work); after an adequate trial of physical or occupational therapy with improvement followed by plateau and not likely to benefit from continued physical or occupational therapy or general conditioning; a defined return to work goal agreed to by the employer and employee; a documented specific job to return to with job demands that exceed abilities or documented on-the-job training; and the worker must be no more than 2 years post date of injury. Guideline criteria have not been met. This patient has not completed physical therapy and been deemed unlikely to benefit from additional therapy or general conditioning. Her job classification is clerical and does not appear to meet criteria of medium or higher demand level. There is no functional assessment documenting limitations that preclude her ability to safely achieve current job demands. She is more than 2 years post date of injury. Therefore, this request for physical therapy 2 times a week for 6 weeks (12) sessions is not medically necessary.

One (1) spinal Q scapular stabilization brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Spinal Q rehab jacket (http://mbracedirect.com/spinal_q_rehab_jacket.php).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: Under consideration is a request for request for one (1) spinal Q scapular stabilization brace. The ACOEM guidelines do not recommend the prolonged use of a sling for symptom control. In general, guidelines recommend 3 weeks use, or less, of a sling after initial shoulder dislocation and reduction. Brief use of sling for severe shoulder pain (1 to 2 days) is recommended with pendulum exercises to prevent stiffness in rotator cuff conditions. Guideline criteria have not been met. There is no documentation of scapular instability or postural deformity to support the use of this brace in the absence of guideline support. Therefore, this request for one (1) spinal Q scapular stabilization brace is not medically necessary.

Voltaren Gel 1%, #6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

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

Decision rationale: Under consideration is a request for Voltaren Gel 1%, #6. The California MTUS states that topical Voltaren is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Guidelines state that it has not been evaluated for treatment of the spine, hip or shoulder. In general, topical NSAIDs (non-steroidal anti-inflammatory drugs) are not recommended for neuropathic pain, as there is no evidence to support use. Guideline criteria have not been met. The patient's main complaints are shoulder and radicular arm pain. Use of this topical gel in the shoulder is not supported by guidelines. Use of topical NSAIDs is not recommended for neuropathic pain. Given the absence of guideline support for use, this request for Voltaren Gel 1%, #6 is not medically necessary.