

Case Number:	CM14-0035182		
Date Assigned:	06/23/2014	Date of Injury:	02/13/2009
Decision Date:	07/24/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/21/2014

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 60-year-old female who reported an injury on 02/13/2009. The mechanism of injury was not provided within the documentation. The injured worker's prior treatments were noted to be ice, heat, rest, NSAIDS, and opioids. The injured worker's diagnoses were noted to be rotator cuff tear, status post right shoulder arthroplasty, cervical spondylosis with radiculopathy and right elbow lateral epicondylitis. The injured worker had a clinical evaluation on 02/25/2014. The injured worker complained of residual pain and discomfort in the right shoulder. The injured worker stated she did self directed stretching activities at home; however, she still has difficulty with activities of daily living. The plan for treatment was a recommendation to continue with conservative measures. It was recommended that the injured worker use topical anti-inflammatory cream as well as wear a spinal Q brace. In addition, the note stated that the spinal Q brace may help to alleviate trapezius muscle spasms. The provider's rationale for the spinal Q brace and provider's rationale for the Voltaren gel was within the clinical evaluation dated 02/25/2014. The request for authorization for medical treatment was signed 03/05/2014, and included the spinal Q brace and topical medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal Q brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar Supports.

Decision rationale: The request for spinal Q brace is not medically necessary. The California MTUS/ACOEM states: lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines do not recommend lumbar supports for prevention. Lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability and for treatment of nonspecific low back pain. The injured worker was provided an order for the spinal Q brace and it is indicated in the clinical evaluation that this might help to alleviate her trapezius muscle spasms. The guidelines do not indicate the use of a support brace for spasms of the trapezius muscles. The injured worker has complaints of residual pain; however, the pain is not rated on a 1-10 scale. It is not documented that conservative care has been failed. According to the evaluation on 02/25/2014, the injured worker does not meet the criteria for a lumbar support as recommended by the guidelines. Therefore, the request for spinal Q brace is not medically necessary.

Voltaren gel 1% times five tubes: 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: The request for Voltaren gel 1% x 5 tubes is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines indicate Voltaren gel for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The clinical evaluation on 02/25/2014 indicates the injured worker having residual pain and discomfort in the right shoulder. The treatment plan indicates use of topical anti-inflammatory cream. However, according to the guidelines, Voltaren gel 1% is not indicated for treatment of inflammatory pain in the spine, hip, or shoulder. The provider did not indicate a topical location of application for the requested cream, nor is there a frequency or a dosage. Therefore, the request for Voltaren gel 1% x 5 tubes is non-certified.