

Case Number:	CM14-0054580		
Date Assigned:	07/11/2014	Date of Injury:	07/03/2009
Decision Date:	09/08/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/23/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 47 year old employee with date of injury of 7/3/2009. Medical records indicate the patient is undergoing treatment for left degenerative joint disease with a complex left shoulder industrial injury. The patient has end-stage arthrosis and is in need of total joint replacement surgery. Subjective complaints include pain persisting around the left shoulder blade and biceps. She complains of numbness and tingling down her right arm (12/16/2013) and as a result of limited use of her upper extremity, she finds activities of daily living to be difficult. She cannot reach behind her back with her left arm and cannot perform overhead activities. Objective findings include: no ecchymosis; no swelling; left rotator cuff atrophy and no deformities on the left. During the exam, she had tenderness to palpation on the left shoulder and diffuse. Crepitus was present on the left. Range of Motion (ROM) on the left showed the following: extension, 20; flexion, 90; adductor, 30 and external rotation to 30. The left side active ROM was restricted due to pain. Muscle Testing proved the following: shoulder flexion, extension and abduction all were 4/5; external rotation was 4/5 and internal rotation was 3/5. MRI of the left shoulder on 11/30/2012 confirmed severe advanced arthrosis of the glenohumeral joint with posterior subluxation of the humeral head on the globoid and posterior facet formation on the globoid. She has moderate advanced a.c. joint arthrosis noted. During exam, her Neer's test was positive on the left, the drop arm test was guarded on the left, negative on the right and the empty can test was negative on both right and left Treatment has consisted of physical therapy (with mild improvement). She has been prescribed Ibuprofen, Symbicort (inhaler), Albuterol sulfate, Voltaren Gel 1%, 100gm and Ventolin HFA inhaler. The utilization review determination was rendered on 4/18/2014 recommending non-certification of Voltaren Gel 1%, 100gm, 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Volatran Gel 1%,100gm, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS specifically states for Voltaren Gel 1% (Diclofenac) that it is "Indicated for 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, hip or shoulder." Medical records do indicate that the patient is being treated for osteoarthritis pain in the shoulder. MTUS does not recommend Voltaren for shoulder arthritic pain, as current evidence based medicine does not support its use at this time. As such the request for Voltaren Gel 1%, 100gm, 2 refills are not medically necessary.