

Case Number:	CM14-0071640		
Date Assigned:	07/16/2014	Date of Injury:	11/22/2004
Decision Date:	09/09/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/13/2014

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 Nevada. 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 records presented for review indicate that this 65-year-old female was reportedly injured on November 22, 2004. The mechanism of injury is noted as repetitive motion. The most recent progress note, dated March 11, 2014, indicates that there are ongoing complaints of right shoulder pain. The physical examination demonstrated decreased cervical spine range of motion with paravertebral tenderness and spasms. There was decreased right shoulder range of motion to include abduction to 85 degrees. There was a positive Hawkins test, Neer's test, and crossover test. Tenderness was noted at the acromioclavicular joint, biceps tendon groove, glenohumeral joint, and subdeltoid bursa. Diagnostic imaging studies of the right shoulder indicated postoperative changes of a previous rotator cuff repair and a complete rupture of the distal supraspinatus and infraspinatus tendons. Previous treatment includes a right shoulder arthroscopy x 2, physical therapy, oral pain medications, psychotherapy, acupuncture, cortisone injections, trigger point injections, epidural steroid injections, chiropractic therapy, the use of a tens unit, and the use of an H wave unit. A request had been made for Voltaren gel and was not certified in the pre-authorization process on April 23, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN GEL 1% APPLY TO AFFECTED BODY PART 2-3TIMES PER DAY AS NEEDED #3: Upheld

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

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

Decision rationale: The California MTUS guidelines support topical NSAIDs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. Additionally the guidelines support 4-12 weeks of topical treatment for joints that are amendable topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the injured employee's diagnosis, date of injury and clinical presentation, this request for Voltaren gel is not medically necessary.