

Case Number:	CM14-0083270		
Date Assigned:	07/21/2014	Date of Injury:	05/16/2011
Decision Date:	09/18/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	06/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 45-year-old female who reported an injury on 05/16/2011 due to an unknown mechanism. Diagnoses were reflex sympathetic dystrophy of the upper extremity, pain, hand, myalgia, and myositis, unspecified, chronic pain due to trauma, chronic opioid analgesic therapy, and pain in joint involving shoulder region. Surgical history was bilateral carpal tunnel, and gastric bypass. Physical examination dated 05/29/2014 revealed complaints of frequency of pain daily. There were complaints of pain that was in the anterior neck, right lateral neck, right posterior neck, right shoulder and right arm. Examination revealed persistent trigger points in the right upper trapezius area. Range of motion for right and left elbow was normal. Range of motion for the right shoulder was painful with limiting factors of pain. Left shoulder was pain was with a normal range of motion. There was pain with left rotation of the head and with left lateral flexion of the head which was more limited and painful than the right lateral flexion. Neurological exam revealed no motor weakness. Medications were Voltaren 1% applied to affected area shoulder 4 times a day, Topiramate 50 mg, Norco 10/325 mg, baclofen 10 mg 1 twice a day as needed for spasms, and amitriptyline HCL 25 mg. Treatment plan was for trigger point injections. The rationale and request for authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

(12) Additional Physical Therapy sessions for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The request for 12 Additional Physical Therapy sessions for the right shoulder is non-certified. California MTUS states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The functional improvement from the physical therapy sessions was not reported. Physical therapy teaches exercises that can be done at home to continue functional improvement and mobility. It was not reported that home exercises were being done. The request exceeds the recommended visits. Therefore, the request is not medically necessary

Voltaren gel 1%: Upheld

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

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

Decision rationale: The request for Voltaren gel 1% is not medically necessary. California MTUS states Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Baclofen 10mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle Relaxant.

Decision rationale: The request for Baclofen 10mg quantity 60 is not medically necessary. This medication is a muscle relaxant. The Official Disability Guidelines indicate for Baclofen is

appropriate for the short-term treatment of insomnia, generally 2 - 6 weeks. The injured worker has been taking this medication longer than recommended. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary