

<b>Case Number:</b>	CM14-0195709		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	07/10/2009
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 Occupational Medicine 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:

Injured worker is a female with date of injury 7/10/2009. Per primary treating physician's progress report dated 10/21/2014, the injured worker complains of right shoulder pain aggravated with overhead activities and lifting. She rates her pain at 4/10. She also complains of right elbow pain aggravated with gripping, grasping, and squeezing, rated at 1/10. She also complains of neck pain aggravated with turning her head, rated at 4/10. She continues to work her usual and customary duties and denies new accidents or injuries. On examination, Jamar grip dynamometer strength readings revealed 26/24/26 kg on the right and 24/24/26 kg on the left. There is tenderness with mild to moderate spasm in the right paracervical musculature, right rhomboid musculature and right trapezius musculature. The right lateral epicondyle is nontender. Diagnoses include 1) sprain/strain of the cervical spine 2) rotator cuff tendinosis, right shoulder impingement syndrome 3) right lateral epicondylitis 4) carpal tunnel, right arm.

### 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 4 weeks for the cervical and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The injured worker is noted to have been injured over five years ago. She recently had six sessions of acupuncture, and then another request for six sessions of acupuncture for the cervical spine and shoulder were denied. There is no report of the total amount of physical therapy that the injured worker has had in the past five years. There is no report of the status of a home exercise program. It would be expected that the injured worker would have completed physical therapy and have the knowledge and ability to carry out a home exercise program for continued rehabilitation and conditioning. The request for Physical therapy 2 times a week for 4 weeks for the cervical and right shoulder is determined to not be medically necessary.

**Voltaren gel 1% with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. 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 injured worker has not been diagnosed with osteoarthritis. Chronic use of NSAIDs is not recommended by the MTUS Guidelines. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Voltaren gel 1% with 1 refill is determined to not be medically necessary.