MAXIMUS Federal Services

| Case Number: | CM15-0006765 | | |
|---|---|---|---|
| Date Assigned: | 01/26/2015 | Date of Injury: | 09/23/2010 |
| Decision Date: | 04/06/2015 | UR Denial Date: | 12/19/2014 |
| Priority: | Standard | Application Received: | 01/13/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Minnesota, Florida
Certification(s)/Specialty: Orthopedic Surgery

## 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 55 year old female with an industrial injury dated 09/23/2010 resulting in an injury to the shoulder. She underwent arthroscopic subacromial decompression of the left shoulder on 9/24/2014. The diagnosis was impingement syndrome, partial thickness rotator cuff tear, and chondromalacia of the glenohumeral joint. She presents for follow up on 11/12/2014 complaining of shoulder pain described as achy and sharp. She rates the pain as 5/10. The injured worker also noted worsening right shoulder pain due to overcompensation. Physical exam revealed shoulder range of motion as follows: Left shoulder Right shoulder; Flexion 140 Degrees Flexion 140 degrees; Abduction 150 degrees Abduction 150 degrees; External rotation 90 degrees External rotation 80 degrees; Internal rotation 60 degrees Not documented. Tenderness was noted at the anterior aspect of bilateral shoulders. The provider notes the injured worker has made good progress in physical therapy for her left shoulder noting that the left shoulder has approached the maximal level of therapy visits. The provider notes with additional physical therapy he thinks her range of motion will continue to improve. The provider also notes the injured worker has not undergone any substantial physical therapy for the right shoulder and would benefit from treatment for this as well. Diagnosis was bilateral shoulder impingement syndrome and status post left shoulder subacromial decompression; grade 2 Chondromalacia of the humeral head and glenoid. On 12/19/2014 Utilization Review modified the request for post- operative physical therapy, twice weekly for 4 weeks left shoulder to post-operative physical therapy twice weekly for 3 weeks. MTUS Guidelines was cited. The request for Ibuprofen 600 mg # 60 was non-certified citing MTUS Guidelines. The request for Voltaren gel 1% # 3 was non-certified citing MTUS Guidelines and Official Disability Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 600 MG Qty 60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** Regarding ibuprofen 600 mg #60 chronic pain medical treatment guidelines indicate NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period of time in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appeared to be superior to acetaminophen particularly for patients with moderate to severe pain. The documentation indicates some pain in both shoulders likely from the underlying condition of chondromalacia that was found at the time of surgery. As such, in light of the moderate pain complaints rated 5/10, the use of ibuprofen was appropriate and medically necessary. Utilization review noncertified the request for lack of evidence of functional improvement from taking ibuprofen. The records indicate that she took Norco for postoperative pain control and at this time switching to ibuprofen was recommended. Therefore there was no documentation of functional improvement from using ibuprofen. Based upon the guidelines the request for ibuprofen is supported and the medical necessity is established.

**Voltaren Gel 1 Percent 100 Gram Qty 3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Voltaren gel Page(s): 111, 112.

**Decision rationale:** With regard to Voltaren gel, chronic pain guidelines indicate it is approved by FDA for relief of osteoarthritis pain in joints that lend 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. It is recommended for short-term use (4-12 weeks) for osteoarthritis and tendinitis, in particular that of the knee and elbow. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. It is not recommended for neuropathic pain as there is no evidence of support. The documentation provided indicates complaint of pain in both shoulders. The guidelines do not recommend use of Voltaren gel for shoulder pain. As such, the request is not supported and the medical necessity is not established.

**Additional Post-Op Physical Therapy, Twice Weekly, Left Shoulder Qty 8:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27, 10, 11.

**Decision rationale:** Regarding the additional physical therapy request, the injured worker had undergone the shoulder decompression in September. She had received a total of 15 postoperative physical therapy treatments. Although there is no objective documentation of continuing functional improvement, the provider's notes indicate that the range of motion was improving and she was in need of additional physical therapy. The provider requested additional postoperative physical therapy twice a week for 6 weeks. California MTUS postsurgical treatment guidelines indicate 24 visits over 14 weeks for impingement syndrome. The initial course of therapy is 12 visits and then with documentation of continuing progressive functional improvement a subsequent course of therapy of 12 visits may be prescribed. The postsurgical physical medicine treatment can extend up to 6 months from the surgical date. The injured worker had completed 15 visits at the time of the request. Objective functional improvement was not documented and physical therapy notes were not provided. However, the provider concluded that additional functional improvement was likely. The request for 8 additional visits was within the guidelines and as such, the medical necessity of the request is established.