

<b>Case Number:</b>	CM15-0185425		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	08/13/1997
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

### 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 50 year old female, who sustained an industrial-work injury on 8-13-97. She reported initial complaints of hip pain. The injured worker was diagnosed as having cervicalgia, other afflictions of shoulder region, and lumbago, lumbosacral disc degeneration. Treatment to date has included medication and diagnostics. Currently, the injured worker complains of hip pain with laying on hips that radiates through legs and rated 6-7 out of 10. Meds include Flexeril, Xanax, Gabapentin, and Ibuprofen and topicals. She is positive on OxyContin old prescription. Per the primary physician's progress report (PR-2) on 7-27-15, exam noted tender spinous process and medial border of scapula as well as left trapezius and para cervical with weakness and marked S1 joint discomfort. There was tenderness at C6-7 dermatome-radicular pain. Shoulder range of motion was full. The Request for Authorization requested service to include Aquatic Therapy, twelve visits for the left shoulder and Voltaren Gel 1% 2-4grm TOP, #100, for thirty days. The Utilization Review on 8-18-15, partially-modified-denied the request for Aquatic Therapy, twelve visits for the left shoulder and Voltaren Gel 1% 2-4grm TOP, #100, for thirty days, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic Therapy, twelve visits for the left shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Shoulder (Acute & Chronic), Physical Therapy, Physical Therapy Guidelines- Rotator Cuff/Impingement Syndrome.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

**Decision rationale:** Aqua-therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. The recommended number of visits follows those recommended for land-based physical therapy. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the therapy). In this case the requested number of 12 visits surpasses the number of six recommended for clinical trial to determine functional improvement. The request is not medically necessary and should not be authorized.

**Voltaren Gel 1% 2-4grm TOP, #100, for thirty days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac.

**Decision rationale:** Voltaren gel is the topical non-steroidal anti-inflammatory drug (NSAID) Diclofenac. Topical NSAIDs have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side-effects comparable to oral form. 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. In this case, there is insufficient documentation in the medical record to support the diagnosis of osteoarthritis. There is no medical indication for the use of Voltaren gel. The request is not medically necessary and should not be authorized.