

<b>Case Number:</b>	CM15-0020235		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	08/21/2007
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 reported an injury on 08/21/2007. The mechanism of injury was not provided. She is diagnosed with shoulder blade pain, cervical spondylosis, subacromial bursitis, and unspecified myalgia/myositis. On 12/16/2014, the injured worker presented with complaints of pain in her neck and shoulders. Her past treatments were noted to include physical therapy, chiropractic treatment, acupuncture, home exercise, surgery, and topical analgesics. It was also noted that she had previous cortisone injection to the shoulder. Her medications were noted to include Voltaren 1% topical gel and Neurontin. Physical examination revealed decreased range of motion of the cervical spine, normal motor strength in the bilateral upper extremities, no tenderness to palpation over the shoulder, and tenderness to palpation over the cervical paraspinal muscles. The treatment plan included a suprascapular injection, acupuncture (as previous visits provided 50% improvement), and refill of Voltaren gel. A specific rationale for the subscapular injection and Voltaren gel was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%, 4 grams topical to right shoulder #1 tubes no refills: Upheld**

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

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

**Decision rationale:** According to the California MTUS Guidelines, Voltaren gel is indicated for relief of arthritis pain in joints that lend themselves to treatment, such as the ankle, elbow, foot, hand, knee, and wrist. However, it has not been evaluated for treatment of the spine, hip or shoulder. The clinical information submitted for review indicates that the injured worker is being treated for shoulder and neck complaints. Therefore, use of Voltaren gel would not be supported. In addition, there was no clear evidence of osteoarthritis in either of these areas. Additionally, the request as submitted did not include a frequency. For these reasons, the request is not medically necessary.

**6 visits of acupuncture for the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Acupuncture.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the California MTUS Guidelines, additional acupuncture treatments should be based on evidence of objective functional improvement with previous treatments. The clinical information submitted for review indicated that the injured worker had 50% improvement with previous acupuncture treatments. However, there was no specific documentation of the number of visits completed and whether there was objective functional improvement. In the absence of this information, additional acupuncture visits are not supported. As such, the request is not medically necessary.

**Suprascapular injection for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines- Steroid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** According to the California MTUS/ACOEM Guidelines, invasive techniques have limited proven value. However, a subacromial injection of corticosteroid may be indicated if there is pain with elevation that significantly limits activities and failure of conservative therapy. The clinical information submitted for review indicated that the injured worker had undergone previous cortisone injections. However, details regarding these injections were not provided to include the region injected, the substance injected, and the outcome in terms of pain relief and functional improvement after previous injections. Additionally, the injured worker was noted to have pain over left shoulder; however, there was an absence of

significant findings on physical examination to warrant an invasive procedure in this area. Therefore, the request is not medically necessary.