

Case Number:	CM15-0223255		
Date Assigned:	11/19/2015	Date of Injury:	07/02/2007
Decision Date:	12/31/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	11/13/2015

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: California

Certification(s)/Specialty: Chiropractor, Oriental 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 67-year-old female, who sustained an industrial injury on 07-02-2007. The injured worker is currently retired. Medical records indicated that the injured worker is undergoing treatment for status post left rotator cuff repair and mild cervical discogenic disease. Treatment and diagnostics to date has included acupuncture and medications. Recent medications have included Omeprazole, Tramadol, Ibuprofen, and Eszopiclone. Subjective data (07-29-2015 and 08-24-2015), included neck and shoulder pain. Objective findings (08-24-2015) included "mild" spasm of the left trapezius muscle and evidence of impingement of the left shoulder. The treating physician noted "the acupuncture is the most significant portion of what has helped her" and "the cream that I gave her (Flurbiprofen) was beneficial." The Utilization Review with a decision date of 10-15-2015 non-certified the request for acupuncture for the neck and left shoulder twice a week for 4 weeks and Voltaren gel 1% 4 oz.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for the neck and left shoulder, twice a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter Official Disability Guidelines (ODG), Acupuncture guideline.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The utilization review determination of 10/15/15 denied the treatment request for acupuncture to the patient's neck and left shoulder, two times per week for four weeks citing CA MTUS acupuncture treatment guidelines. The patient's prior history of treatment before the November 7, 2015 request included acupuncture management of chronic neck and left shoulder pain. The reviewed medical records reflect at least eight acupuncture treatments provided to the left shoulder prior to the November 7, 2015 request with records not establishing any clinical evidence of objective improvement, decrease and medication use or evidence of work modification secondary to acupuncture application. The medical necessity for the requested additional eight visits of acupuncture care to the neck and left shoulder was not supported by the reviewed medical records or compliance with CA MTUS acupuncture treatment guidelines prerequisites that require evidence of functional improvement the for consideration of additional treatment. This request is not medically necessary.

Voltaren gel 1% 4 oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain. Voltaren Gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The utilization review determination of 10/15/15 denied the request for Voltaren gel 1% 4 ounces stating that the use of this topical gel was not recommended as a first-line treatment and was recommended as a course of care for osteoarthritis after a failure of oral anti-inflammatories or a patient's contraindications to oral anti-inflammatories. The reviewed medical records did not identify the patient as demonstrating on examination evidence of osteoarthritis or a past medical history of intolerance to anti-inflammatory medication. The medical necessity for the dispensing of Voltaren gel 1% 4 ounces was not supported by the reviewed medical records or the prerequisites for use of this topical medication per CA MTUS chronic treatment guidelines. This request is not medically necessary.