

Case Number:	CM15-0034327		
Date Assigned:	03/02/2015	Date of Injury:	11/16/2010
Decision Date:	04/21/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/24/2015

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 66-year-old female who reported injury on 11/16/2010. Diagnosis was herniated nucleus pulposus cervical spine. The mechanism of injury was not provided. Therapies included physical therapy and chiropractic care. The injured worker underwent an arthroscopy extensive debridement, right excision distal clavicle, and subacromial decompression of the right shoulder on 02/05/2014. The injured worker underwent postoperative physical therapy. There was a Request for Authorization form submitted for review dated 01/20/2015. The injured worker underwent MRIs and x-rays. The documentation of 01/19/2015 revealed the injured worker had complaints of pain. The injured worker was noted to have positive impingement signs and bilateral spasms in the cervical spine and tenderness to palpation in the rhomboids. The office note was handwritten and difficult to read. The diagnoses included right rotator cuff tear status post rotator cuff repair. The treatment plan included chiropractic care 2 x6 for the neck and 2 shoulder, and physical therapy for the neck and shoulder 2 x6 as well as Voltaren gel to apply to the affected area once a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic services 2 times a week for 6 weeks for cervical & right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4-6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The clinical documentation submitted for review failed to provide the injured worker's prior objective benefit received from the requested chiropractic care. There was a lack of documentation of objective improvement and the quantity of sessions previously attended. The request for 12 sessions would be excessive. Given the above, the request for chiropractic services 2 times a week for 6 weeks for cervical & right shoulder is not medically necessary.

Physical Therapy 2 times a week for 6 weeks for Cervical & Right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. 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 California Medical Treatment Utilization Schedule states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical therapy. There was a lack of documentation indicating objective functional benefit and remaining objective functional deficits. The quantity of sessions previously attended were not provided. There was a lack of documented rationale for the physical therapy request. There was a lack of documentation of exceptional factors. Given the above, the request for physical therapy 2 times a week for 6 weeks for cervical & right shoulder is not medically necessary.

Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends 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. 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 clinical documentation submitted for review failed to provide documentation of osteoarthritis. Additionally, the medication has not been evaluated for the shoulder. There was a lack of documentation indicating the body part to be treated. The request as submitted failed to indicate the frequency and quantity of Voltaren gel as well as the body part to be treated. Given the above, the request for Voltaren gel 1% is not medically necessary.