

Case Number:	CM15-0047458		
Date Assigned:	03/19/2015	Date of Injury:	03/08/2012
Decision Date:	05/05/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/12/2015

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: Illinois, California, Texas
 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 44-year-old female who sustained an industrial injury on 3/08/12. The mechanism of injury was not documented. The 12/08/14 treating physician report stated that Voltaren gel was helping decrease her pain by 40% during the day and she was taking pain medication at night. The 2/05/15 treating physician report cited right greater than left shoulder, neck and upper back pain. She reported that she "can't take it anymore". She had doubled up on medications and was using TENS unit and over-the-counter anti-inflammatories. Physical exam documented subacromial tenderness to palpation, right greater than left, positive arc and impingement, equivocal drop arm test, pain over the back of the shoulder, and trapezius spasms. The patient was diagnosed with bilateral shoulder and neck pain. The treatment plan recommended right shoulder arthroscopic subacromial decompression, and prescribed Norco, Relafen, and Voltaren gel. She was to continue at full duty status. The 2/13/15 utilization review non-certified the request for right shoulder surgery and associate post-operative Norco, as there was no imaging evidence provided and no documented conservative treatment failure. The request for Voltaren gel was non-certified as there was no evidence that she was intolerant of oral non-steroidal anti-inflammatory drugs (NSAIDs).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view. An MRI, ultrasound, or arthrogram showing positive evidence of impingement is required. Guideline criteria have not been met. This patient presents with persistent right shoulder pain. Clinical exam findings suggest impingement. However, there was no evidence of a diagnostic injection test. There were no imaging reports in the available records to document positive evidence of impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Norco 10/325 po q 3-6 hrs prn #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): s 76-80 and 91.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Voltaren gel apply to shoulder q 12h 100gm: 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): s 111-113.

Decision rationale: The California MTUS states that topical Voltaren is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Guidelines state that it has not been evaluated for treatment of the spine, hip or shoulder. Guideline criteria have not been met. There is no evidence that this patient is intolerant of oral non-steroidal anti-inflammatory drugs (NSAIDs) to support medical necessity of a topical formulation. An oral NSAIDs has been prescribed. There is no compelling reason to support an additional topical agent. Additionally, there is no evidence of efficacy for shoulder complaints. Therefore, this request is not medically necessary.