

<b>Case Number:</b>	CM15-0085316		
<b>Date Assigned:</b>	05/07/2015	<b>Date of Injury:</b>	09/28/2009
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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: 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:

This 60 year old man sustained an industrial injury on 9/28/2009 while unloading a thermal cart. Evaluations include left shoulder x-ray dated 8/9/2013, right hip x-ray dated 8/9/2013, left shoulder MRI dated 8/31/2013, and right hip MRI dated 8/31/2013. Diagnoses include left shoulder biceps tendinosis, left shoulder severe acromioclavicular degenerative joint disease, anterior shoulder impingement, and right hip greater trochanteric bursitis. Treatment has included oral medications, physical therapy, acupuncture, steroid injection, and surgical intervention. Physician notes on a PR-2 dated 3/5/2015 show complaints of left shoulder rated 4/10 and right hip pain rated 6-7/10. Recommendations include activity and lifting restrictions, use right shoulder sling, Norco, Ambien, Zofran, Ketoprofen cream, ice therapy, physical therapy, and follow up in two weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 100mg Qty: 1.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints for the acute first few weeks; however, it not recommended for long-term use beyond the initial few weeks of treatment as in this chronic injury. Submitted reports have not demonstrated significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID nor is there a contraindication to an oral NSAID use for this patient. The Voltaren gel 100mg Qty: 1.00 is not medically necessary and appropriate.

**Physical therapy, right hip Qty: 8.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Physical medicine guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy, right hip Qty: 8.00 is not medically necessary and appropriate.