

Case Number:	CM14-0165355		
Date Assigned:	10/10/2014	Date of Injury:	07/17/2012
Decision Date:	12/18/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/07/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 36-year-old male with a 7/17/12 date of injury. According to a progress report dated 9/4/14, the patient felt his pain has improved status post right shoulder arthroscopy on 5/16/14. He stated that he did feel pain at night with some difficulty sleeping, particularly when he would lie on his right shoulder. He has regained almost full range of motion of his right shoulder, but he did complain of decreased ability to adduct the right arm as well as internally rotate. Objective findings: full active range of motion of right shoulder, pain with O'Brien's, Speed's, Yergason's, weakness demonstrated with elbow flexion and supination at 4/5, negative impingement signs. Diagnostic impression: right shoulder partial-thickness rotator cuff tear and Superior Labrum Anterior and Posterior (SLAP) tear, status post right shoulder arthroscopy, anterior labral repair, and biceps tenodesis. Treatment to date: medication management, activity modification, surgery, physical therapy. A UR decision dated 9/16/14 denied the request for Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 100gm: 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 9792.24.2 Topical Analgesics Page(s): 112.

Decision rationale: CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and has not been evaluated for treatment of the spine, hip or shoulder. However, in the present case, there is no documentation that this patient has a diagnosis of osteoarthritis. In addition, guidelines do not support the use of Voltaren gel for the shoulder. Furthermore, a specific rationale regarding why this patient cannot tolerate oral medications was not provided. Therefore, the request for Voltaren Gel 1% 100gm is not medically necessary.