MAXIMUS Federal Services

Case Number:	CM15-0175788		
Date Assigned:	09/17/2015	Date of Injury:	04/04/2014
Decision Date:	10/26/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/08/2015

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:

The injured worker is a 56-year-old female who sustained an industrial injury on April 4, 2015. Diagnoses have included right shoulder rotator cuff sprain, rotator cuff tear, and pain in shoulder joint. Documented treatment includes right shoulder arthroscopic rotator cuff repair on April 24, 2015; as of August 24, 2015 she is in the process of attending 8 authorized sessions of physical therapy; home exercise; and, she has been taking medication including Tylenol 3 and Roboxin. July 27, 2015 report states functional improvement and reduction of pain with medication bringing reported level from 9 to 5 out of 10. The physician states that the injured worker has had bariatric surgery and is unable to tolerate oral NSAIDs. She has signed an opioid treatment agreement. The injured worker continues to present with right shoulder pain and tenderness. August 24, 2015 examination states range of motion includes flexion at 90 degrees with 180 degrees being "normal," extension 35 degrees versus 40 degrees normal, abduction 90 degrees versus 180 degrees, internal rotation 60 degrees versus 80 degrees, and external rotation 50 degrees versus 90 degrees being normal. She has increased pain with "extremes of all ranges of motion." The treating physician's plan of care includes a urine drug screen and Voltaren gel with one refill. Both were denied September 2, 2015. She is presently not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary, updated 07/15/2015.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter under Urine Drug Testing.

Decision rationale: The patient presents with pain in the right shoulder. The request is for Urine Drug Screen. Patient is status post right shoulder surgery, date unspecified. Physical examination to the right shoulder on 08/24/15 revealed tenderness to palpation over the medial and lateral aspects of the shoulder. Range of motion wad limited with pain in all planes. Per Request For Authorization form dated 08/24/15, patient's diagnosis include rotator cuff tear of the right shoulder, and status post right shoulder arthroscopic rotator cuff repair. Patient's medications, per 05/04/15 progress report include Tylenol #3 and Robaxin. Per 08/24/15 progress report, patient is to remain off work until 10/08/15. MTUS Chronic Pain Medical Treatment Guidelines 2009, for Drug Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. ODG-TWC Guidelines, online, Pain chapter for Urine Drug Testing states: Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. The treater has not discussed this request. Review of the medical records provided did not indicate prior urine screen testing. The patient had been utilizing opioids (Tylenol #3 and Robaxin) since at least 05/04/15. ODG states that an annual screening is sufficient for "chronic opiate use in low risk patient. The request appears to be reasonable and is within the guideline recommendations and therefore, is medically necessary.

Voltaren gel 100gm with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary, online version updated 07/15/2015.

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

Decision rationale: The patient presents with pain in the right shoulder. The request is for Voltaren Gel 100gm With 1 Refill. Patient is status post right shoulder surgery, date unspecified. Physical examination to the right shoulder on 08/24/15 revealed tenderness to palpation over the medial and lateral aspects of the shoulder. Range of motion wad limited with pain in all planes. Per Request For Authorization form dated 08/24/15, patient's diagnosis include rotator cuff tear of the right shoulder, and status post right shoulder arthroscopic rotator cuff repair. Patient's medications, per 05/04/15 progress report include Tylenol #3 and Robaxin. Per 08/24/15 progress report, patient is to remain off work until 10/08/15. MTUS Chronic Pain Medical Treatment Guidelines 2009, Topical Analgesics section, under Non-steroidal anti-inflammatory agents, page 111-112 has the following: "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during

the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2- week period." "...this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In progress report dated 08/24/15, the treater is prescribing Voltaren Gel because the patient has had bariatric surgery and cannot tolerate oral NSAIDs. Review of the medical records provided did not indicate a prior use and it appears that the treater is initiating this medication. The patient continues with pain in the right shoulder. MTUS guidelines state that "there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." Due to lack of support from MTUS guidelines, the requested Voltaren Gel is not medically necessary.