

Case Number:	CM15-0096594		
Date Assigned:	05/26/2015	Date of Injury:	09/28/2009
Decision Date:	06/25/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/19/2015

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 61 year old male sustained an industrial injury to the back, right shoulder, bilateral hands/wrist, right foot and right hip on 9/28/09. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture, injections and medications. Magnetic resonance imaging right hip (8/31/13) showed bilateral hip degenerative spurring with probable bilateral acetabular labral tear. The injured worker underwent left shoulder decompression with distal clavicle resection on 2/19/15. In a PR-2 dated 3/18/15, the injured worker had completed three postoperative physical therapy sessions. The physician noted that the injured worker had received more than 24 physical therapy sessions for the left shoulder. The injured worker complained of right hip pain rated 6/10 on the visual analog scale with radiation of numbness and tingling to the right lower extremity, no lower than his right knee. The injured worker reported that Voltaren gel decreased his pain. Current diagnoses included left shoulder biceps tendinosis, left shoulder severe acromial degenerative joint disease, left shoulder impingement and right hip greater trochanteric bursitis. The treatment plan included weight bearing as tolerated, continuing Voltaren gel, cold compression therapy for postoperative pain and swelling, postoperative physical therapy to the right shoulder twice a week for six weeks and physical therapy for the right hip twice a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 100gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Per Guidelines, Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc.) for the acute first few weeks; however, it not recommended for long-term use beyond the initial few weeks of treatment for this chronic injury. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Recent report noted chronic pain symptoms with unchanged activity level. Clinical exam is without acute changes or report of flare-up for this chronic injury. The Voltaren gel 100gm is not medically necessary and appropriate.

Physical therapy, right hip: Upheld

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

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 is not medically necessary and appropriate.