MAXIMUS Federal Services

Case Number:	CM14-0017173		
Date Assigned:	04/25/2014	Date of Injury:	10/15/2012
Decision Date:	05/29/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/11/2014

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 Physical Medicine and Rehabilitation 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:

The patient is a 50 year old female who was injured on 10/15/2012. The mechanism of injury is unknown. Prior treatment history has included Menthoderm gel. The patient underwent right shoulder arthroscopy with subacromial decompression. Physical therapy note dated 07/24/2013 states the patient has attended therapy 18/18 sessions since the last report. The patient reports variable right shoulder and parascapular area persists with current pain scale rating ranging from 5-9/10. The patient reports intermittent numbness to her 5th digit. The patient reports sleep remains interrupted. The patient reports pain limits range of motion. She is in compliance with and has good tolerance for home program. On exam, range of motion of the right shoulder AROM flexion to 40 degrees; abduction to 30 degrees; external rotation to 40 degrees, and reaching behind the back is 25% of normal. Motor strength in the right shoulder is 4+/5 in available range. Right grip is 30 lbs; left is 80 lbs; sensation is grossly intact to light touch, note above paresthesias. There is impaired proportional to the requirement for right shoulder motor and mobility demand. PR2 dated 01/23/2014 reports the patient states the pain and mobility in her right shoulder are slowly improving with therapy. The pain in her wrist and elbow are much improved. Objective findings on exam revealed there is 150 degrees of forward elevation, 60 degrees of external rotation, and internal rotation to L2 at the right shoulder with some pain. There is slight trapezial and parascapular tenderness. The Tinel's sign is positive at the right cubital tunnel. The elbow flexion test is equivocal on the right. There is minimal radial tunnel tenderness on the right. The Tinel's sign and Phalen's test are negative at the carpal tunnels. There is mild crepitus with range of motion at the right shoulder. Grip strength is diminished on the right. Diagnoses are status post right ASAD; trapezial, paracervical and parascapular strain; resolving right wrist sprain; resolving right medial and lateral epicondylitis; and resolving right radial tunnel syndrome. The treatment plan is to have the patient continue with physical therapy

twice weekly for the next 6 weeks to work on stretching, modalities, and rotator cuff strengthening. She should continue with her nonsteroidal anti-inflammatory lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE RIGHT SHOULDER QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Postsurgical Treatment Guidelines, post-operative physical therapy of 24 visits over 14 weeks is recommended for the diagnosed condition of status post right shoulder arthroscopic subacromial decompression. A physical therapy progress report dated 07/24/2013 indicates that the examinee has attended 18 therapy visits. A prior UR report indicates that the patient has been approved for 21 post-operative visits to date. There is documentation that the patient has functional improvement with prior physical therapy treatments. However, the patient has continued to remain temporarily totally disabled. Additionally, the request for additional 12 sessions of physical therapy for right shoulder exceeds the guidelines recommendation. The request for physical therapy for the right shoulder, quantity 12 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST (DOS: 1/23/14) FOR MENTHODERM GEL 120GM: 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, Page(s): 111-113.

Decision rationale: According to the California MTUS guidelines, topical angalgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, this patient has chronic right shoulder pain and has been prescribed Menthoderm gel. However, there is no documentation that the patient has tried and failed the first-line medication therapy including antidepressants and anticonvulsants. Also, there is no documentation that the patient is intolerant to similar oral medications. Additionally, Methoderm contains menthol and methyl salicylate and guidelines indicate that topical salicylate is significantly better than placebo in chronic pain. The retrospective request (DOS: 1/23/14) for Menthoderm gel 120gm is not medically necessary and appropriate.