

Case Number:	CM14-0175609		
Date Assigned:	10/28/2014	Date of Injury:	06/29/2012
Decision Date:	12/04/2014	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	10/22/2014

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 Sports Medicine and is licensed to practice in Virginia and Texas. 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 injured worker is a 67-year-old female who reported an injury on 06/29/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of right shoulder acromioclavicular separation, right shoulder impingement syndrome, right shoulder rotator cuff syndrome, right shoulder rotator cuff rupture, right shoulder acromioclavicular joint osteoarthritis, and right shoulder rotator cuff tendonitis. Past medical treatment consists of surgery, physical therapy, injections, and medication therapy. Medications consist of Atorvastatin, tramadol, "Buspirone," lorazepam, metformin, Lisinopril, and hydrocodone/APAP. No diagnostics were submitted for review. On 08/25/2014, the injured worker complained of right shoulder pain. The physical examination noted that the pain rate was 7/10. It was also noted the injured worker had tenderness to palpation of the right shoulder. Range of motion revealed a flexion of 165 degrees, extension to 40 degrees, abduction to 155 degrees, adduction to 45 degrees, internal rotation to 45 degrees, and external rotation to 55 degrees. Impingement test, Neer's test, Hawkins-Kennedy, Codman's drop arm, and Speed's test were positive on the right. The medical treatment plan is for the injured worker to continue with physical therapy and medication therapy. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two (2) times a week for four (4) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for physical therapy 2 times a week for 4 weeks is not medically necessary. The submitted documentation did not indicate the efficacy of the prior physical therapy. Additionally, there was no indication as to how many physical therapy sessions the injured worker has had to date. Furthermore, as per the guidelines active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are also instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It was not documented in the submitted reports that the injured worker was continuing with a home exercise program. Furthermore, the request as submitted did not indicate what extremity the provider was requesting the physical therapy for. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.

Urine Toxicology Test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Steps to Avoid Misuse/Addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The request for urine toxicology test is not medically necessary. The submitted documentation failed to submit any urinalysis of the injured worker. Additionally, there was no rationale submitted for review to warrant a urinalysis. There was no documented evidence of the injured worker having signs of dependence or addiction, nor was there any reason to assume that the injured worker had the presence of illegal drugs. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.

Flurbiprofen 20%, Tramadol 20%, In Mediderm Base Topical Cream, #210gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for Flurbiprofen 20% Tramadol 20% In Mediderm Base Topical Cream, #210gm is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker might have had. The MTUS Guidelines recommend topical analgesics are primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed.

There was no pertinent evidence submitted for review showing that the injured worker had trialed and failed any antidepressants or anticonvulsants. Furthermore, the request as submitted did not indicate a frequency or duration of the medication, nor did it specify where the topical cream was going to be used. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.