

Case Number:	CM14-0031043		
Date Assigned:	06/20/2014	Date of Injury:	06/14/2013
Decision Date:	07/18/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/12/2014

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 & 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 59-year-old female who reported an injury on 05/14/2013 due to repetitive motion while performing normal job duties. The injured worker reportedly sustained an injury to her right shoulder, right arm, right knee, and right hand. The injured worker underwent right shoulder surgery on 10/21/2013 followed by postoperative physical therapy. The injured worker was evaluated on 02/03/2014. It was noted that the injured worker complained of right shoulder pain rated at 4/10 to 6/10, left knee pain rated at a 3/10 to 5/10, and neck pain radiating into the right upper extremity. Physical findings of the right shoulder documented tenderness to palpation of the subacromial region and AC joint and supraspinatus tendon. Range of motion described as 120 degrees in flexion on the right and 130 degrees on the left, 30 degrees of extension on the right and 50 degrees on the left, 80 degrees of abduction on the right and 180 degrees on the left, and 25 degrees in adduction on the right and 45 degrees on the left. Internal rotation is 50 degrees on the right and 80 degrees on the left, and external rotation is 70 degrees on the right and 90 degrees on the left. Evaluation of the left knee documented tenderness to palpation over the lateral joint and the parapatellar region with a positive McMurray's test and range of motion described as 130 degrees in flexion and zero degrees in extension. It was noted that the injured worker had a disturbed sensation in the right C5 distribution, decreased motor strength of the right shoulder. The injured worker's diagnoses included cervical musculoligamentous sprain/strain with right upper extremity radiculitis, left knee sprain with patellofemoral arthralgia, and status post right shoulder arthroscopy with distal clavicle excision and SLAP repair with adhesive capsulitis. The injured worker's treatment plan included medications and physical therapy, and an electrodiagnostic study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 sessions per week for 4 weeks (12 sessions) for the right shoulder:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule recommends 24 sessions for postsurgical management of rotator cuff/impingement syndrome. The clinical documentation indicates that the injured worker has participated in approximately 20 sessions of postoperative physical therapy. The requested 12 sessions in combination with the already completed 20 sessions exceeds guideline recommendations. There are no exceptional factors to support extending treatment outside of the guideline recommendations. As such, the requested physical therapy for the right shoulder is not medically necessary or appropriate.

Electromyography (EMG) of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California Medical Treatment Utilization Schedule recommends 24 sessions for postsurgical management of rotator cuff/impingement syndrome. The clinical documentation indicates that the injured worker has participated in approximately 20 sessions of postoperative physical therapy. The requested 12 sessions in combination with the already completed 20 sessions exceeds guideline recommendations. There are no exceptional factors to support extending treatment outside of the guideline recommendations. As such, the requested physical therapy for the right shoulder is not medically necessary or appropriate.

Nerve Conduction Study (NCS) of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California Medical Treatment Utilization Schedule recommends 24 sessions for postsurgical management of rotator cuff/impingement syndrome. The clinical documentation indicates that the injured worker has participated in approximately 20 sessions of postoperative physical therapy. The requested 12 sessions in combination with the already

completed 20 sessions exceeds guideline recommendations. There are no exceptional factors to support extending treatment outside of the guideline recommendations. As such, the requested physical therapy for the right shoulder is not medically necessary or appropriate.

Ultracin topical lotion: Upheld

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

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

Decision rationale: The requested medication is a compounded topical medication that contains methyl salicylate, menthol, and Capsaicin. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol in the management of chronic pain related to degenerative joint disease; however, the California Medical Treatment Utilization Schedule does not support the use of Capsaicin unless the injured worker has failed to respond to first line chronic pain management treatments to include antidepressants and anticonvulsants. The clinical documentation submitted for review does not provide any evidence of that the injured worker has failed to respond to first line medications, and would require a topical agent such as Capsaicin. Furthermore, the request as it is submitted does not provide a dosage, frequency, or applicable body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Ultracin topical lotion is not medically necessary or appropriate.