

Case Number:	CM14-0032429		
Date Assigned:	06/20/2014	Date of Injury:	02/14/2013
Decision Date:	07/17/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/14/2014

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 Illinois. 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 54-year-old female who reported an injury on 02/14/2013. The mechanism of injury was noted to be a fall. Prior treatments include physical therapy, medication, home exercises, and knee surgery. Her diagnoses were noted to be left shoulder impingement, left biceps tendinitis, and status post ACL reconstruction. In a recent clinical note dated 10/24/2013 it was noted that the injured worker had active range of motion to the knee flexion on the left was 110 degrees and extension on the left was -3. It was also noted that passive range of motion to the left knee was 0 to 115 degrees with guarding. Left shoulder passive range of motion was flexion 150 degrees with moderate to maximum guarding; left elbow flexion, extension, passive range of motion 0 to 115 degrees with heavy guarding. Strength values were left elbow 4/5, left shoulder 4/5, left hip 4/5, and left knee 3/5. It was noted that therapy was unable to test the left shoulder due to heavy guarding; no knee test due to the current ACL tear; positive left lateral epicondylitis test; stiffness in the patella, increased stiffness in the 1st rib; stiffness also in the proximal radioulnar and elbow joint. It was noted there was tenderness to palpation over the left lateral forearm/elbow and near the olecranon fossa. There was tenderness in the left upper trapezius, levator scapula/scalene and lateral/anterior shoulder and tenderness in the left posterior knee. The therapist noted that the injured worker had progressed with physical therapy; however, had not met all the therapeutic goals. The injured worker had been demonstrating compliance with the prescribed home exercise program. The injured workers' problems were noted to be increased pain and muscle spasms, decreased gait and balance, decreased range of motion, decreased strength, poor posture/body mechanics, and decreased education. The recommendation was for the injured worker to request additional physical therapy due to 0 visits left on the current prescription. The request for authorization for medical treatment is dated 02/11/2014. The provider's rationale for

the requested therapy was not provided within the documentation. The provider's rationale for the requested Terocin cream or Voltaren gel is not provided either.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued use of Terocin Cream or equivalent (Voltaren 5% gel): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesics Page(s): 105, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113 Page(s): 111-113.

Decision rationale: The request for continued use of Terocin cream or equivalent Voltaren 5% gel is non-certified. The California MTUS, Chronic Pain Medical Treatment Guidelines note Terocin is a topical pain relief lotion that contains methyl salicylate, capsaicin, menthol, and lidocaine. The guidelines identify these agents are compounded as monotherapy or in combination for pain control; ketoprofen, lidocaine in creams, lotions, or gels, capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested Terocin cream contains at least 1 drug (lidocaine) that is not recommended. Therefore, based on the guidelines and the review of the evidence, the request for Terocin cream is non-certified.

Additional Physical Therapy 2x4 for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for additional physical therapy 2 times a week for 4 weeks for the left shoulder is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines indicate a recommendation for physical therapy. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active, self-directed home physical medicine. The guidelines allow 8 to 10 visits over 4 weeks. The documentation provided for review indicates the injured worker had physical therapy to the left shoulder 8 visits completed on 10/24/2013. It is noted within the information provided for review that the injured

worker does home exercises. It is noted on the last of the 8 physical therapy session progress notes that the injured worker's shoulder range of motion was 130 degrees of flexion, 120 degrees scaption, 110 degrees abduction, 50 degrees extension, 50 degrees in neutral position, and 50 degrees in neutral position. Active range of motion to the left elbow was 0% extension, 110% flexion. Based on the values from the previous visit, the injured worker has made progress with therapy. The guidelines provide 8 to 10 visits over 4 weeks. Additional physical therapy, up to 2 more visits, would be appropriate under the guidelines with self-directed home therapy to followup. However, the request is for 8 more physical therapy sessions to the left shoulder. This is in excess of the guidelines. Therefore, the request for additional physical therapy 2 times a week x 4 weeks for the left shoulder is non-certified.

Additional Post op Physical Therapy for left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99, Postsurgical Treatment Guidelines Page(s): 25.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

Decision rationale: The request for additional postoperative physical therapy for the left knee is non-certified. The California MTUS Postsurgical Treatment Guidelines indicate postsurgical physical medicine treatment following ACL repair may include up to 24 visits of physical therapy over 16 weeks. The postsurgical physical medicine treatment period is 6 months. The injured worker is status post ACL reconstruction. It is noted the surgical procedure occurred in 11/2013. It was noted within the documentation that the injured worker had participated in post-op physical therapy following her knee surgery, although there is no documentation noting current range of motion values or motor strength numbers. It was also not documented how many post-op visits the injured worker has used. The request for additional post-op physical therapy for the left knee fails to indicate the number of visits requested. Therefore, the request for additional post-op physical therapy for the left knee is non-certified.