

<b>Case Number:</b>	CM14-0035756		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	01/20/2005
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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:

This 53 year-old patient sustained an injury on 1/20/05 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy for the right shoulder with rotator cuff protocol 2x3 times a weeks for 6 weeks and Flurbiprofen 20% cream, and Ketoprofen 20% Ketamine 10% cream 120gm. Diagnoses include status post right shoulder arthroscopy with rotator cuff repair on 1/16/14; status post hardware removal at C4-6 with cervical decompression/fusion at C3-4 on 1/4/12; status post MVA (Motor Vehicle Accidents) with sprain/strain on 3/6/13; bilateral upper extremity radiculopathy; Left CTS (Carpal Tunnel Syndrome); Left shoulder subacromial impingement syndrome; and thoracic spine musculoligamentous sprain/strain. Conservative care has included Physical Therapy, anti-inflammatory medications, subacromial injections, and modified activities/rest. There is utilization review with certification of 12 sessions of post-operative Physical Therapy for shoulder surgery. Report of 2/24/14 from the provider noted the patient with constant chronic right shoulder pain rated at 8-10/10 associated with numbness and tingling. Current medications list Ibuprofen. Exam showed Request(s) for Physical Therapy for the right shoulder with rotator cuff protocol 2x3 times a weeks for 6 weeks and Flurbiprofen 20% cream, and Ketoprofen 20% Ketamine 10% cream 120gm were non-certified on 3/13/14 citing guidelines criteria and lack of medical necessity.

### 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 with rotator cuff protocol 2x3 times a weeks for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Postsurgical physical medicine treatment, Postsurgical Treatment Guidelines.

**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 Physical Therapy treatment already rendered including milestones of increased ROM (Range of Motion), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, nonspecific clinical findings, and work 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 physical therapy with fading of treatment to an independent self-directed home program. The patient was certified for at least 12 post-operative Physical Therapy visits for the arthroscopic repair performed almost 7 months ago; however without identified number of visits completed or demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic shoulder repair over a rehab period of 6 months. The Physical Therapy for the right shoulder with rotator cuff protocol 2x3 times a weeks for 6 weeks is not medically necessary and appropriate.

**Flurbiprofen 20% cream:** 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): 111-113.

**Decision rationale:** Submitted reports have not adequately documented the indication and necessity of this topical analgesic for this 2005 injury with chronic pain whereby the patient is already taking multiple other oral medications. There is no demonstrated functional improvement from ongoing refills of medication. Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. 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 Non-Steroid Anti-Inflammatory Drugs (NSAIDs) (which is also concurrently prescribed) or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. The Flurbiprofen 20% cream is not medically necessary and appropriate.

**Ketoprofen 20% Ketamine 10% cream 120gm:** 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): 111-113.

**Decision rationale:** Submitted reports have not adequately documented the indication and necessity of this topical analgesic for this 2005 injury with chronic pain whereby the patient is already taking multiple other oral medications. There is no demonstrated functional improvement from ongoing refills of medication. Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. 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 (which is also concurrently prescribed) or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. Of particular note, Ketoprofen cream is an agent not currently FDA approved for a topical application due to an extremely high incidence of photo contact dermatitis. The Ketoprofen 20% Ketamine 10% cream 120gm is not medically necessary and appropriate.