

<b>Case Number:</b>	CM15-0002095		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	07/16/2013
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 43-year-old female who reported an injury on 01/06/2013. The mechanism of injury involved heavy lifting. The current diagnosis is status post subacromial depression of the right shoulder with residual loss of range of motion and weakness. The injured worker presented on 05/30/2014, for a re-evaluation. The injured worker reported stiffness and pain in the right shoulder. It is noted that the injured worker is status post subacromial decompression in 02/2014, followed by 15 postoperative physical therapy sessions. Upon examination of the right shoulder, there was 90 degree forward flexion and abduction, 45 degree external rotation, internal rotation to T10, negative orthopedic testing, 4/5 weakness, and 2+ deep tendon reflexes. Recommendation included a course of supervised physical therapy. The injured worker was also given a refill of ibuprofen and Prilosec. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 1xWk x 6Wks Right 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, Physical Therapy

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

**Decision rationale:** The California MTUS Guidelines state 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. While it is noted that the injured worker has diminished range of motion and weakness in the right shoulder, there was no documentation of the previous course of physical therapy, with evidence of objective functional improvement. Therefore, the current request is not medically appropriate at this time.

**IF Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. There is no documentation of a failure to respond to previous conservative treatment to include TENS therapy prior to the request for an interferential stimulator unit. Additionally, a 1 month trial is recommended prior to a unit purchase. There is no documentation of a successful 1 month trial with the interferential stimulator unit prior to the request for a unit purchase. Given the above, the request is not medically appropriate.

**TGHot 180gm:** 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 Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. Gabapentin is not recommended, as there is no peer reviewed literature to support its use as a topical product. There is also no strength or frequency listed in the above request. As such, the request is not medically appropriate.

**Fluriflex:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, and NSAIDs, Osteoarthritis (including knee and.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Muscle relaxants are not recommended for topical use. There is also no strength, frequency, or quantity listed in the above request. As such, the request is not medically appropriate.