

<b>Case Number:</b>	CM15-0007721		
<b>Date Assigned:</b>	01/23/2015	<b>Date of Injury:</b>	10/11/2012
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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 62-year-old male who reported an injury on 10/11/2012. The mechanism of injury was not provided. His diagnoses include status post 2 arthroscopic surgeries on the left shoulder and 1 on the right, right shoulder AC joint arthrosis, right shoulder partial thickness rotator cuff tear, and right shoulder mild residual impingement. His past treatments were noted to include injection into the shoulder, home exercise, and medications. The injured worker's symptoms included left shoulder pain radiating to the elbow and right shoulder pain radiating to the shoulder blade and right trapezius muscles. Physical examination revealed decreased range of motion to both shoulders and evidence of impingement bilaterally. The treatment plan included a refill of Methoderm ointment and continued home exercises. A specific rationale for the requested Methoderm ointment and range of motion testing was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methoderm Ointment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Topical Analgesic Page(s): 105; 111-113.

**Decision rationale:** According to the California MTUS Guidelines, salicylate topicals are recommended, as they were significantly better than placebo in chronic pain. The guidelines also state that topical analgesics are largely experiment in use and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines specify that use of compounded topical agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The clinical information submitted for review indicated that the injured worker had bilateral shoulder pain and was given a refill of Methoderm ointment. However, details regarding his past use of Methoderm ointment were not provided, including the duration of use and whether it had been effective in terms of pain relief and increased function. In addition, the documentation did not indicate the specific therapeutic goal of Methoderm in combination with methyl salicylate, and it was not indicated whether the injured worker had failed methyl salicylate alone prior to using Methoderm ointment. For these reasons, continued use of Methoderm ointment is not supported. In addition, the request as submitted failed to indicate a frequency, quantity, and body part to be applied. For these reasons, the request is not medically necessary.

**Range of Motion testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Flexibility.

**Decision rationale:** According to the Official Disability Guidelines, computerized range of motion testing is not recommended, as range of motion can be tested with inclinometers during physical examination, and results of computerized range of motion testing are of unclear therapeutic value. The clinical information submitted for review indicated that the injured worker's range of motion was tested in the bilateral shoulders at his visit on 11/26/2014. A clear rationale for the range of motion testing requested was not provided. As the guidelines do not recommend specialized range of motion testing over use of inclinometers during physical examination, the request is not supported. As such, the request is not medically necessary.