

<b>Case Number:</b>	CM15-0148840		
<b>Date Assigned:</b>	08/13/2015	<b>Date of Injury:</b>	08/09/2014
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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 female, who sustained an industrial injury on August 9, 2014. The injured worker was diagnosed as having cervical, thoracic and bilateral shoulder strain- sprain, right scapula dyskinesia, infraspinatus atrophy and supraspinatus nerve impingement. Treatment to date has included physical therapy and medication. A progress note dated June 11, 2015 provides the injured worker complains of neck, shoulder and back pain. He rates his neck pain unchanged at 6 out of 10, the left shoulder 6 out of 10 decreased from 7, right shoulder 9 out of 10 unchanged and back pain 8 out of 10 increased from 6. Physical exam notes cervical tenderness to palpation with spasm, decreased range of motion (ROM) and positive compression test. There is tenderness to palpation of the thoracic paraspinal area with decreased range of motion (ROM) and bilateral shoulder tenderness to palpation with decreased range of motion (ROM) and positive impingement. There is a request for physical therapy and topical medication.

### 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 x 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation Official Disability Guidelines, Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**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 PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional 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 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2014 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy for the right shoulder x 8 is not medically necessary and appropriate.

**Compound Topical Medication: Flurbiprofen, Baclofen, Camphor, Menthol, Dexamethasone, Capsaicin, Hyaluronic Acid:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** 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 compound analgesic over oral NSAIDs or other pain relievers for a patient with multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic to include a compounded NSAID, muscle relaxant and Capsaicin over oral formulation for this chronic injury without documented functional improvement from treatment already rendered. Guidelines do not recommend long-term use of NSAID without improved functional outcomes attributable to their use. Additionally, Guidelines do not recommend long-term use of this muscle relaxant and Capsaicin medications for this chronic injury without improved functional outcomes attributable to their use. The Compound Topical Medication: Flurbiprofen, Baclofen, Camphor, Menthol, Dexamethasone, Capsaicin, Hyaluronic Acid is not medically necessary and appropriate.