

<b>Case Number:</b>	CM15-0029928		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	10/01/2012
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

### 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 57 year old female, who sustained an industrial injury on 11/29/12. She has reported back and shoulder injury. The diagnoses have included rotator cuff syndrome shoulder, displacement lumbar intervertebral disc without myelopathy, thoracic/lumbosacral neuritis/radiculitis and sprain/strain of knee and leg. Treatment to date has included right shoulder arthroscopic decompression and debridement, physical therapy and pain medication. Currently, the injured worker complains of lumbar spine, right shoulder, left hip pain and right knee pain. Progress note dated 1/5/15 noted pain was improved with pain medication, rest and therapy. Tenderness was noted to the paraspinals, decreased strength and sensation at left L4, 5 and S1, decreased range of motion of right shoulder and decreased range of motion of right knee with tenderness over the medial and lateral joint lines. On 1/30/15 Utilization Review non-certified additional course of physical therapy 2 times a week for 6 weeks, noting the limited documentation to support the claimant has tried and failed a home exercise program and no mention of recent flare-ups and Flurbiprofen/Lidocaine cream (20%/5%) 180gm, noting the lack of documentation of failed trials of anticonvulsant and antidepressant therapy. The MTUS, ACOEM Guidelines, was cited. On 2/6/15, the injured worker submitted an application for IMR for review of additional course of physical therapy 2 times a week for 6 weeks and Flurbiprofen /Lidocaine cream (20%/5%) 180gm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional course of physical therapy 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ODG-TWC physical therapy guidelines.

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

**Decision rationale:** The patient is a 57 year old female with a date of injury of 11/29/2012. She had a back and shoulder injury and had right shoulder surgery. She had back, shoulder, hip and knee pain. She had physical therapy and instruction of a home exercise program. The request is for an additional 12 visits of physical therapy. First, the requested 12 visits exceeds the MTUS total number of visit is allowed. Second, the patient previously had physical therapy and instruction in a home exercise program. At this point in time relative to the injury and surgery, the patient should have been transitioned to a home exercise program and there is no objective superiority of continued formal physical therapy over a home exercise program. The additional 12 visits of physical therapy are not medically necessary.

**Flurbiprofen/Lidocaine cream (205/5%) 180g: 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:** The patient is a 57 year old female with a date of injury of 11/29/2012. She had a back and shoulder injury and had right shoulder surgery. She had back, shoulder, hip and knee pain. She had physical therapy and instruction of a home exercise program. MTUS guidelines note that if one active ingredient of a compound topical analgesic is not recommended then the entire compound is not recommended. In this case both the NSAIDS component and the lidocaine cream component are not recommended. The requested compound medication is not consistent with MTUS guidelines and is not medically necessary.