

Case Number:	CM15-0219233		
Date Assigned:	11/12/2015	Date of Injury:	10/27/2013
Decision Date:	12/23/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	11/06/2015

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: Preventive Medicine, Occupational Medicine

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 58 year old female, who sustained an industrial injury on 10-27-2013. She has reported injury to the right shoulder. The diagnoses have included right shoulder supraspinatus and infraspinatus full-thickness tears, partial tear of the subscapularis and biceps tendon; left shoulder pain, secondary to overuse; and right hip pain, clinical bursitis. Treatment to date has included medications, diagnostics, rest, ice, sling, bracing, and physical therapy. Medications have included Motrin and Flexeril. In the physical therapy progress report, dated 09-17-2015, the injured worker reports her pain level as 5 out of 10 in intensity to the right hip; she "feels physical therapy is helping". The objective findings included unchanged range of motion of the right hip. The assessment included "the patient is progressing slower than expected"; the initial pain value was rated at 8 out of 10 in intensity; and the current pain value is rated at 5 out of 10 in intensity. A progress report from the treating physician, dated 09-21-2015, documented a follow-up visit with the injured worker. The injured worker reported frequent right shoulder pain, rated as 5 out of 10 in intensity; frequent right hip pain, rated as 6 out of 10 in intensity; she has been authorized for rotator cuff repair; she is currently on therapy for her right hip and is doing better; she has had some improvement in her right hip bursitis; the pain is made worse with activities and change in weather; the pain is made better with rest, medications, and therapy; and she is currently not working. Objective findings included limited range of motion of the right shoulder due to pain; Hawkins and drop arm signs were positive; examination of the right hip revealed mild pain with range of motion; examination of the lumbar spine revealed mild tenderness; and neurovascular exam was normal. The treatment plan has included the request for physical therapy right hip 2 times a week for 6 weeks; and Flurbiprofen, Baclofen,

Lidocaine cream (20%-5%-4%) sig-apply a thin layer 2-3 times per day or as directed to (body part(s) not specified). The original utilization review, dated 10-19-2015, non-certified the request for physical therapy right hip 2 times a week for 6 weeks; and Flurbiprofen, Baclofen, Lidocaine cream (20%-5%-4%) sig-apply a thin layer 2-3 times per day or as directed to (body part(s) not specified).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right hip 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. In this case, the injured worker has previously completed at least 8 sessions of physical therapy and should be able to continue with a self-paced, home-based exercise program. The request for physical therapy right hip 2 times a week for 6 weeks is determined to not be medically necessary.

Flurbiprofen/Baclofen/Lidocaine cream (20%/5%/4%) sig; apply a thin layer 2-3 times per day or as directed to (body part(s) not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain), NSAIDs (non-steroidal anti-inflammatory drugs), Topical Analgesics.

Decision rationale: The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Topical NSAIDs, have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. The injured worker's pain is not described as pain from osteoarthritis. Topical flurbiprofen is not an FDA approved formulation. The MTUS Guidelines state that there is no evidence for use of muscle relaxants, such as Baclofen, as a topical product. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. As at least one of the medications in the requested compounded medication is not recommended by the guidelines, the request for Flurbiprofen/Baclofen/Lidocaine cream (20%/5%/4%) sig; apply a thin layer 2-3 times per day or as directed to (body part(s) not specified) is determined to not be medically necessary.