

Case Number:	CM14-0157911		
Date Assigned:	10/01/2014	Date of Injury:	10/17/2013
Decision Date:	10/29/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/26/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 38-year-old male auto parts sales manager sustained an industrial injury on 10/17/13. Injury occurred due to the repetitive stocking of car batteries on a 6-foot high shelf. The patient underwent right shoulder diagnostic arthroscopy, subacromial decompression with acromioplasty, limited debridement and synovectomy, and platelet-rich plasma injection on 4/4/14. Records indicated that the patient had been approved for 24 post-op physical therapy sessions. The 6/25/14 treating physician report cited persistent right upper extremity and shoulder pain radiating up to the cervical spine. Pain was frequent and grade 7/10. Pain reduced to grade 3/10 with Norco and Anaprox. The patient had completed 10 physical therapy visits and noted improvement in his symptoms. Range of motion testing documented flexion 150, internal rotation 50, and external rotation 60 degrees with 4/5 shoulder strength. The treatment plan recommended additional physical therapy 2x6, and refilled Naprosyn. Kera-Tek analgesic gel was prescribed to maintain painful symptoms, restore activity, and aid in functional restoration as he was intolerant to other treatment including activity restrictions and home exercises. The 9/9/14 utilization review denied the 6/27/14 request for 12 additional physical therapy sessions as the patient had been certified for 12 visits initial visits on 3/10/14 and 12 additional physical therapy sessions had been approved on 5/28/14. The patient had not completed the full complement of post-op approved therapy at the time of this request, therefore it was deemed premature. The request for Kera-Tek gel was denied as there was no support for use in the shoulder. Records indicated that the patient had completed 24 post-op physical therapy visits as of 7/31/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right shoulder quantity requested 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This patient had been approved for 24 post-op physical therapy visits consistent with post-surgical treatment guidelines. At the time of this request, there were 14 approved visits remaining. There is no compelling reason to support the medical necessity of additional supervised therapy prior to completion of authorized therapy and documentation of residual functional deficits. Therefore, this request is not medically necessary.

Kera-tek analgesic gel; apply 2-3 times daily, 4 oz quantity requested: 1.00: 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 Topical analgesics Page(s): 111-113.

Decision rationale: Kera-Tek gel is a compound containing menthol and methyl salicylate. The California MTUS guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that efficacy in clinical trials of non-steroidal anti-inflammatory (NSAIDs) agents has been inconsistent and most studies are small and of short duration. Guidelines state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of shoulder. Menthol is a topical cooling agent that guidelines support as an optional form of cryotherapy. Guideline criteria have not been met. The patient was concurrently prescribed an oral anti-inflammatory for shoulder pain. The medical necessity of a topical NSAID in addition to oral NSAID is not supported by a compelling rationale. The use of topical NSAIDs in shoulder complaints is not supported by guidelines. Therefore, this request is not medically necessary.