

Case Number:	CM15-0124300		
Date Assigned:	07/08/2015	Date of Injury:	02/02/2015
Decision Date:	08/05/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/29/2015

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 47-year-old male who sustained an industrial injury on 02/02/15. Initial complaints and diagnoses are not available. Treatments to date include medications and physical therapy. Diagnostic studies include a MRI of the right shoulder on 03/23/15, which was a limited evaluation due to decreased signal to noise ratio, but showed suggested joint capsule thickening without adhesive capsulitis or tear. Current complaints include right shoulder pain. Current diagnoses include right shoulder strain, right shoulder long head of the biceps tendonitis and strain, and right shoulder capsular strain. In a progress note dated 05/11/15 the treating provider reports the plan of care as medications including Ultram, Soma, Kera-Tek gel, and Hydrocodone, as well as additional physical therapy. The requested treatments include Ultram, Kera-Tek gel, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 sessions of physical therapy for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) (physical therapy) (2015).

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

Decision rationale: Review indicates the patient has completed at least 17 PT visits. 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 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 Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous 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 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 12 sessions of physical therapy for the right shoulder is not medically necessary and appropriate.

Kera-tek gel 4 oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals.

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

Decision rationale: Kera-Tek analgesic gel was requested. Keta-tek has active ingredients of methyl salicylate and menthol. 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 analgesic compound over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medication. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this injury beyond guidelines criteria. The Kera-tek gel 4 oz is not medically necessary.

120 Ultram 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pages 74-96.

Decision rationale: Review indicates the request for Ultram was modified for #30. MTUS Guidelines cite opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use

of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing results or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain rated at VAS 10/10 for this injury without acute flare, new injury, or progressive deterioration. The 120 Ultram 50mg is not medically necessary.