

Case Number:	CM15-0173236		
Date Assigned:	09/15/2015	Date of Injury:	07/10/2010
Decision Date:	10/14/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/02/2015

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 43 year old female, who sustained an industrial injury on July 10, 2010. She reported left shoulder pain. The injured worker was diagnosed as having status post shoulder left scope, rotator cuff sprain and bilateral rotator cuff tendinosis. Treatment to date has included diagnostic studies, right shoulder surgery, right shoulder injection, medications and work restrictions. Currently, the injured worker continues to report bilateral shoulder pain, worse on the right than the left. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. She was without resolution of the pain. Evaluation on July 27, 2015, revealed continued pain as noted. She noted pain with range of motion of the right shoulder. The left shoulder was noted as improved with therapy and surgical intervention. Evaluation on August 17, 2015, revealed continued pain as noted. It was noted she was nearly 8 months status post left shoulder scope. It was noted she had full range of motion in the left shoulder with remarkable improvements since the surgical intervention and physical therapy. However, it was noted the right shoulder symptoms have worsened. There was noted right shoulder impingement and pain with rotator cuff loading. A right shoulder injection was administered. The RFA included requests for Lidopro4%-27.5%-0.0325% topical ointment that was non-certified and Physical therapy Qty: 12 that was modified on the utilization review (UR) on August 26, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Review indicates PT request was modified for 2 visits post shoulder injection. The patient is s/p left shoulder arthroscopy in January 2015, over 9 months past with chronic guidelines applicable. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. 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. Submitted reports have no new injury or specific neurological deficit progression to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The physical therapy Qty: 12 is not medically necessary or appropriate.

Lidopro4%-27.5%-0.0325% topical ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Chronic symptoms and clinical findings remain unchanged with medication refilled. The patient exhibits diffuse tenderness and pain on the exam to bilateral shoulders and extremities. The chance of any type of topical improving generalized symptoms and functionality significantly with such diffuse pain is very unlikely. Topical Lidocaine is indicated for post-herpetic neuralgia, according to the manufacturer. There is no evidence in any of the medical records that this patient has a neuropathic source for the diffuse pain. Without documentation of clear localized, peripheral pain to support treatment with Lidocaine along with functional benefit from treatment already rendered, medical necessity has not been established. There are no evidenced-based studies to indicate efficacy of capsaicin 0.0325% formulation and that this increase over a 0.025% formulation would provide any further efficacy over oral delivery. There is no documentation of intolerance to oral medication as the patient is also on other oral analgesics. The Lidopro4%-27.5%-0.0325% topical ointment is not medically necessary or appropriate.