

<b>Case Number:</b>	CM13-0059978		
<b>Date Assigned:</b>	04/28/2014	<b>Date of Injury:</b>	11/04/2011
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Physical Medicine and Rehabilitation, 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:

The injured worker is a 58-year-old male who reported an injury on 11/04/2011. The mechanism of injury was reported as a lifting injury. The injured worker underwent a mini open left rotator cuff repair in March 2012, and a manipulation under anesthesia to the same in October 2012. According to the clinical note dated 11/26/2013, the injured worker reported continued pain and difficulties with his left shoulder, and his pain rated at 7-8/10. The physician reported tenderness over the left acromioclavicular (AC) joint and strength of 4-/5. Forward flexion was one hundred twenty (120) degrees and abduction was one hundred (100) degrees. A nerve conduction study dated 09/23/2013, was reportedly negative for any nerve entrapment or cervical radiculopathy in the left upper extremity. A magnetic resonance (MR) arthrogram performed on 10/25/2013, revealed a five (5) mm full thickness rotator cuff re-tear and AC joint arthrosis to the left shoulder. The request for authorization for medical treatment was dated 10/01/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REFILL MEDICATIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
FUNCTIONAL RESTORATION APPROACH TO CHRONIC PAIN MANAGEMENT  
Page(s): 7.

**Decision rationale:** According to the Chronic Pain Guidelines, the choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one (1) pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding the prescribing information and adjust the dosing to the individual patient. The request does not specify the names, dosages, or quantities of the medications requested to compare to the evidence based guidelines. Therefore the request, for refill medications is non-certified.

**ANALGESIC CREAMS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TOPICAL ANALGESICS Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TOPICAL ANALGESICS Page(s): 111-112.

**Decision rationale:** According to the Chronic Pain Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine the effectiveness or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The request does not specify the names, dosages, or quantities of the medications requested to compare to the evidence based guidelines. Therefore the request for Analgesic Creams is non-certified.