

Case Number:	CM13-0060140		
Date Assigned:	12/30/2013	Date of Injury:	06/29/2006
Decision Date:	07/21/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	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 Occupational Medicine and is licensed to practice in California, Colorado, Michigan, Pennsylvania and Texas. 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:

Prior treatment history has included medication, 10 cortisone injections of the right shoulder and one cortisone injection of the left knee and physical therapy. The patient underwent right shoulder arthroscopic rotator cuff repair on 08/21/2006, revision of rotator cuff repair on 08/16/2007 and revision of rotator cuff repair and arthroscopic debridement of labrum on 10/04/2007; left total knee arthroplasty on 03/12/2009. Diagnostic studies reviewed include CT arthrogram of the patient of the right shoulder dated 07/07/2010 revealed a focal tear involving the rotator cuff interval, acromioclavicular osteoarthritis. Primary Treating Physician's Follow-Up note dated 09/24/2013 reported the patient had complaints of right shoulder pain rated as 9/10, and left knee pain rated on 9/10 on a numerical pain scale. The patient reported continued relief with cortisone injection to the right shoulder from pain. Objective findings revealed tenderness to palpation over the supraspinatus. Range of motion revealed flex to 88 degrees on the right and 180 degrees on the left; extension to 30 degrees on the right and 50 degrees on the left; abduction to 65 degrees on the right and 180 degrees on the left; adduction to 30 degrees on the right and 50 degrees on the left; Internal rotation to 40 degrees on the right and 90 degrees on the left; and external rotation to 40 degrees on the right and 90 degrees on the left. Upon examination, impingement and empty-can supraspinatus tests are positive on the right shoulder. Upper extremity motor strength exam was 5/5 bilaterally except for shoulder abductors which was 4/5 on the right and 5/5 on the left; shoulder flexors 4/5 on the right and 5/5 on the left. Knee range of motion revealed flexion to 120 degrees on the right and 89 degrees on the left. There is a well-healed scar noted of the left knee. Lower extremity motor strength exam revealed hip flexion, knee extensors, knee flexion, great toe extensor, foot evetors on the right is 5/5; hip flexion, knee extensors, knee flexion, great toe extensor, foot evetors on the left is 4/5. The patient is diagnosed with status post left total knee replacement surgery in 2009 and status

post right shoulder surgery x2. A request was made for medications to be dispensed which include Norco, Prilosec, Omeprazole, Ibuprofen, Tramadol and topical cream. Medication Summary Report dated 08/27/2013 which yielded inconsistent results detecting Cotinine, hydroxybuproion, Nicotine, and hydrocodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUNDED TOPICAL CREAM APPLIED TWICE DAILY TO AFFECTED SKIN AREAS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

Decision rationale: The requested topical analgesic includes the ingredients of NSAID, Ketamine and Amitriptyline. The Chronic Pain Medical Treatment guidelines for topical NSAIDs state "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration." Further, the use of topical Ketamine is under study and is "only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." There is no indication that the patient has a refractory case that has failed all primary and secondary treatment. Based on the guidelines cited and medical documentation, the request is not medically necessary.