

Case Number:	CM13-0060486		
Date Assigned:	12/30/2013	Date of Injury:	05/09/2011
Decision Date:	03/10/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	11/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 physician 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 is a patient of the date of injury of May 9, 2011. A utilization review determination dated November 15, 2013 recommends non-certification of interferential unit, flurbiprofen cream, and gabacyclotran. A progress report dated December 3, 2013 includes subjective complaints of lumbar spine pain. The patient also has bilateral shoulder pain with numbness and stiffness. Objective findings include tenderness and spasm in the shoulders with limited range of motion. Diagnoses include a left shoulder history of surgery, rule out left shoulder capsulitis, right shoulder history of surgery, and lumbar spine discopathy. The treatment plan recommends Ultram, Zolof, Prilosec, and referral to pain management. A progress report dated November 5, 2013 includes subjective complaints including circled letters which seem to infer right and left shoulder pain. Objective findings have letters circled which seem to infer bilateral shoulder tenderness to palpation and reduced range of motion. Diagnoses include left shoulder history of surgery, rule out left shoulder capsulitis, and right shoulder history of surgery. Treatment plan recommends old tram, Prilosec, Zolof, flurbiprofen cream, and a compound medication including gabapentin, cyclobenzaprine, and tramadol. An interferential unit is also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: Regarding the request for topical flurbiprofen, guidelines state that topical NSAIDs (non-steroidal anti-inflammatory drugs) are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical flurbiprofen is for short term use, as recommended by guidelines. Additionally, guidelines state that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine or shoulder. The request for Flurbiprofen cream is not medically necessary or appropriate

Gabacyclotran: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: Regarding request for a topical compound, the requested topical compound is a combination of gabapentin, cyclobenzaprine, and ultram. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding topical gabapentin, guidelines state that gabapentin is not recommended for topical use. Additionally, guidelines do not support the use of topical opiate pain medication, such as Ultram. Furthermore, guidelines do not support the use of any muscle relaxant as a topical product. The request for Gabacyclotran is not medically necessary or appropriate

An interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: Regarding the request for interferential unit, Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that

the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement. The request for an interferential unit is not medically necessary or appropriate