

Case Number:	CM13-0068954		
Date Assigned:	01/03/2014	Date of Injury:	09/15/2011
Decision Date:	05/23/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/20/2013

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 Internal Medicine, 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 patient is a 46-year-old male with a 9/15/11 date of injury, and status post left shoulder partial labral resection, partial thickness rotator cuff tear debridement, subacromial decompression, and resection of coracoacromial ligament on 3/21/13. His subjective complaints include right shoulder pain rated 2-3/10, left shoulder pain rated 4/10, and pain increased with overhead activities, and objective findings include left shoulder FF 170/180, extension 40/50, abduction 160/180, and adduction 40/50. His current diagnoses include status post left shoulder arthroscopy as of 3/21/13, left shoulder impingement syndrome, and gastritis secondary to medications, and treatment to date has been medications and HEP.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLURBIPROFEN 20% GEL 120GM, KETOPROFEN 20%, KETAMINE 10% GEL 120GM: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines states that many agents are compounded as monotherapy or in combination for pain control. Guidelines also state that that ketoprofen is not recommended for topical applications, and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

GABAPENTIN 10%, CYCLOBENZAPRINE 10%, CAPSAICIN .0375% 120GM #1:
Upheld

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines states that many agents are compounded as monotherapy or in combination for pain control. Guidelines also state that that capsaicin in a 0.0375% formulation, and gabapentin are not recommended for topical applications, and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.