

Case Number:	CM13-0068977		
Date Assigned:	01/03/2014	Date of Injury:	03/19/2012
Decision Date:	06/04/2014	UR Denial Date:	11/18/2013
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 Orthopedic Surgery and is licensed to practice in Pennsylvania. 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 50-year-old female who was injured on 03/09/12. The clinical records indicate bilateral shoulder complaints for which the claimant is status post a January 2013 right shoulder rotator cuff repair and has undergone a significant course of aggressive postoperative physical therapy. The recent clinical assessment of 11/09/13 for follow up of the right shoulder documents an examination showing 160 degrees of abduction and forward flexion and the left shoulder showing 160 degrees of forward flexion and 140 degrees of abduction. The documentation noted healed scars on both shoulders. There was positive tenderness with Speed's testing, impingement testing, and supraspinatus testing bilaterally. The treating physician documented bilateral bicipital groove tenderness and performed bilateral bicipital groove corticosteroid injections on that date. This is a retrospective request for the injections performed on 11/09/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL BICIPITAL GROOVE CORTISONE INJECTION DONE ON 11/9/13:

Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition, (web) 2011 as well as Chronic Pain Medical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment In Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Steroid Injections.

Decision rationale: The California ACOEM Guidelines and the Official Disability Guidelines support the use of steroid injections for the shoulders for the diagnoses of impingement, adhesive capsulitis, or rotator cuff syndrome. In this incidence, the claimant's examination shows specific pain over the bicipital groove and has failed other forms of conservative care in her postoperative course including an aggressive physical therapy. While peer-reviewed literature does not specifically address bicipital groove injections, the claimant's diagnosis of an acute inflammatory process and no documentation of prior injection therapy would have supported the need of injection performed on 11/09/13 bilaterally.

COMPOUNDED CREAM (CYCLOBENZAPRINE 10%/GABAPENTIN 10%/FLURBIPROFEN 20%/ TRAMADOL 10%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition, (web) 2011 as well as Chronic Pain Medical Treatment Guidelines.

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

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, the topical compound containing Cyclobenzaprine, Gabapentin, Flurbiprofen, and Tramadol would not be indicated. Any topical compound for which an active ingredient is not supported by the Chronic Pain Guideline criteria as a whole is not supported. Presently, there is no indication for the topical use of Gabapentin, Tramadol, or Cyclobenzaprine in the topical setting. Chronic Pain Guidelines do not support the use of these agents topically. The absence of support for the above three agents would fail to support the need of the topical compound as a whole.

PHYSICAL THERAPY FOR THE SHOULDERS AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition, (web) 2011 as well as Chronic Pain Medical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Based on California MTUS Chronic Pain Guidelines, continued physical therapy for the shoulders and lumbar spine would not be indicated. This individual has documentation of shoulder complaints dating back to rotator cuff repair over one year ago with no current acute exam findings to support the need for further physical therapy based on therapy that has already been utilized. There is also no documentation of clinical findings in regard to the

low back. The specific clinical request in this case would not be indicated at this chronic time frame from the claimant's injury.