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| Case Number: | CM14-0001792 | | |
| Date Assigned: | 03/03/2014 | Date of Injury: | 09/30/2011 |
| Decision Date: | 09/29/2014 | UR Denial Date: | 12/17/2013 |
| Priority: | Standard | Application Received: | 01/06/2014 |

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 was a 42-year-old female who reported an injury on 09/30/2011. The mechanism of injury was noted to be repetitive reaching, lifting, and pushing activities. She was diagnosed with having rotator cuff strain. Prior treatments were noted to be medications and physical therapy. The injured worker was noted to have diagnostic testing of NCV/EMG and MRI. Surgical history was noted to be carpal tunnel release. A clinical evaluation on 11/04/2013 was the most recent clinical evaluation with this review. The subjective complaints of the injured worker were noted to be pain in the right shoulder described as constant, minimal to slight at rest, increasing to moderate to severe with activities involving the right upper extremity for pushing, pulling, heavy lifting, or use of the right arm at shoulder level or above. Objective data under the physical examination was noted to be range of motion of the right upper extremity was noted to be 160 degrees with forward flexion, 150 degrees with abduction, and 70 degrees with external rotation. The rotator cuff exam noted a positive Neer, positive Hawkin's, and positive Jobe test. Tenderness was present as well as a positive stress test over the anterior AC joint. Motor strength deficits with abduction and external rotation were slightly impaired on the right upper extremity. Updated diagnoses were noted to be symptomatic right shoulder impingement syndrome and distal clavicle arthrosis. The treatment recommendation was for a subacromial cortisone injection, a renewal of physical therapy for modalities and strengthening exercises, and renewal of anti-inflammatory medications. The rationale for the request was partially provided. The Request for Authorization form was not provided for the request within this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOTRIN CREAM (MOTRIN 10%/5%): 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 Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Motrin cream (Motrin 10%/5%) is not medically necessary. California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy 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. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or class of drug that is not recommended is not recommended. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Topical NSAIDs are not indicated for neuropathic pain as there is no evidence to support their use. The clinical evaluation submitted for review does not indicate a failed trial of antidepressants or anticonvulsants. It did not indicate an objective reason for a topical Motrin as opposed to an oral route. The Guidelines do not recommend topical NSAIDs. This was noted to be a refill; there was no indication of prior efficacy with previous use. The provider's request did not indicate a frequency or a quantity. As such, the request for Motrin cream (Motrin 10%/5%) is not medically necessary.

TOPHROPHAN: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Enovachem Manufacturing is cGMP and CFR Compliant, FDA and DEA Registered Manufacturer, and State Board of Pharmacy Licensed.

Decision rationale: The request for Toprophan is not medically necessary. The Guidelines do not address Toprophan. According to Enovachem Manufacturing who happen to be CFR Compliant, FDA and DEA registered, as well as State Board of Pharmacy licensed, Toprophan is a nutritional supplement. This nutritional supplement consists of vitamin B6, l-tryptophan, chamomile, valerian extract, melatonin, inositol, and other ingredients. The combination of these ingredients may aid patients in falling and staying asleep. Suggested use is 1 capsule, 1 half hour before bedtime, preferably on an empty stomach. The clinical evaluation did not indicate an objective reason for a sleep aid. There is not a diagnosis of insomnia noted within

the clinical evaluation submitted for review. The request fails to indicate a dosage, frequency, and quantity requested. Therefore, the request for Toprophan is not medically necessary.