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| <b>Case Number:</b>   | CM14-0007537 |                              |            |
| <b>Date Assigned:</b> | 02/10/2014   | <b>Date of Injury:</b>       | 11/26/2013 |
| <b>Decision Date:</b> | 06/24/2014   | <b>UR Denial Date:</b>       | 01/20/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/21/2014 |

### 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 Orthopedic Surgery and is licensed to practice in 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:

The injured worker is a 32 year old male who sustained an injury on 11/26/13 due to multiple injuries including assault. The injured worker had been followed for complaints of both neck and right shoulder pain. The injured worker had previously been treated with physical therapy in December of 2013. The injured worker had a follow up on 12/17/13 with persistent complaints of pain in the right shoulder and right upper extremity. The injured worker reported increased pain with physical therapy which included stretching exercises, electrical stimulation, and iontophoresis. Medications did include Meloxicam. The injured worker continued to report pain in the right shoulder with range of motion. On physical examination, there was intact range of motion in the bilateral shoulders. Positive impingement signs to the right shoulder were noted. There was tenderness to palpation over the coracoacromial ligament as well as the subacromial space. No neurological deficit was identified. Radiographs of the right shoulder were reported to show a type 2 acromion with downsloping and subacromial spurring. The injured worker was given an injection of the right shoulder at this evaluation which resulted in improvement of pain. MRI studies were recommended to rule out rotator cuff tears. The injured worker was also recommended for further physical therapy for 8-12 sessions. The injured worker was also prescribed antiinflammatories and topical medications for pain. This included Voltaren XR 100mg, Ultracet 37.5/325mg, and a topical compounded medication that included Flurbiprofen, Ketoprofen, Ketamine, Gabapentin, and Cyclobenzaprine. The injured worker was also provided a heating system and a Transcutaneous Electronic Nerve Stimulator (TENS) unit for pain. Follow up on 01/21/14 noted persistent weakness in the right shoulder on abduction and external rotation. Positive Spurling's signs to the right were noted. MRI studies were again recommended at this evaluation. The requested MRI of the right shoulder, topical medications, a solar care

heating system, x-force stimulator, and physical therapy were all denied by utilization review on 01/20/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **MRI (MAGNETIC RESONANCE IMAGE) OF THE RIGHT SHOULDER: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** In regards to the requested MRI of the right shoulder, the injured worker did present with positive impingement signs with weakness at the right shoulder on rotator cuff strength testing. This reviewer did have access to additional records indicating that MRI studies were completed on 02/11/14. Given the injured worker's presentation to include rotator cuff weakness as well as positive impingement signs, this reviewer would have recommended the MRI of the right shoulder as medically necessary.

#### **TOPICAL CREAM: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** In regard to the use of a topical cream, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. Per the reports, the injured worker was recommended for a compounded topical medication that included Flurbiprofen, Ketoprofen, Ketamine, Gabapentin, and Cyclobenzaprine. The California Medical Treatment Utilization Schedule (CAMTUS), Chronic Pain Treatment Guidelines and US FDA note the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen, Ketoprofen, Ketamine, Gabapentin, and Cyclobenzaprine which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Furthermore, there was no rationale regarding the use of multiple NSAID. Therefore, this compound would not have been supported as medically necessary.

#### **SOLARCARE FIR(FAR INFRARED) HEATING SYSTEM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER CHAPTER, HOT AND COLD THERAPY

**Decision rationale:** In regards to the solar care heating system, this reviewer would not have recommended this durable medical equipment as medically necessary. Although hot and cold therapy for musculoskeletal joint pain is supported by guidelines, there is no indication from the clinical record that a specific heating system is supported over any other commercially available heating pads or hot packs. The clinical literature does not establish that any substantial functional improvements are obtained with one particular heating system over over the counter remedies. Therefore, this durable medical equipment would not have been supported as medically necessary.

**X-FORCE STIMULATOR (TRANSCUTANEOUS NERVE STIMULATION FOR PAIN):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Seven Seas DM Website

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES TRANSCUTANEOUS ELECTROTHERAPY Page(s): 113-117.

**Decision rationale:** In regards to the use of a Transcutaneous Electronic Nerve Stimulator (TENS) unit such as an x-force stimulator, this reviewer would not have recommended this durable medical equipment as medically necessary. Per guidelines, the use of a Transcutaneous Electronic Nerve Stimulator (TENS) unit in shoulder conditions is supported following cerebrovascular accidents to improve range of motion. Otherwise, the use of TENS units for the shoulder is not supported by high quality clinical studies. There was also no indication that the injured worker was continuing with a formal physical therapy program in which a TENS unit was being utilized and resulted in substantial functional improvement or pain reduction. There is also no documentation of an adequate trial of a TENS unit which resulted in functional improvement that would support the purchase of this type of system. Therefore, this would not have been supported as medically necessary.

**PHYSICAL THERAPY (FREQUENCY AND DURATION NOT INDICATED):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE Page(s):  
98-99.

**Decision rationale:** In regards to the requested physical therapy, the clinical records recommended physical therapy for an additional 8-12 sessions. The clinical information did not identify any substantial functional benefits obtained with previous physical therapy that would support its ongoing use. Furthermore, no specific goals were established with the recommendation of physical therapy to support its use. Therefore, this would not have been supported as medically necessary.