

<b>Case Number:</b>	CM14-0016777		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	06/29/2011
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 51-year-old male who is reported to have sustained work related injuries on 06/29/11. It is reported that on the date of injury, the injured worker was a passenger in a small cart while his coworker was driving. The coworker drove off a sidewalk into the dirt causing the cart to sway back and forth. Subsequently it is reported that the injured worker struck his right shoulder against a lock on a hard plastic window, which resulted in immediate pain to his right shoulder. Records indicate that the injured worker was identified as having a rotator cuff tear. On 12/13/11, he underwent arthroscopic right shoulder and biceps tendon repair. Postoperatively, therapy is reported to have worsened his pain and symptoms. On 12/27/12, he was returned to surgery and underwent an arthroscopic right shoulder labral and biceps tear repair surgery. Records indicate that postoperatively the injured worker developed pain in the left shoulder. An MRI is reported to have revealed a torn tendon due to compensating with his right shoulder. The injured worker currently complains of pain in the right shoulder pain, which radiates into the right bicep and posteriorly into the shoulder blade. He reports constant muscle spasms, twitching, popping, and a grinding sensation in his shoulder, which has become worse. He reports tingling in the right arm and hand. Range of motion is worse. He is treated with oral medications, heating pads, and ice packs. On physical examination, it is noted that there are multiple scars on the right shoulder. There is right greater than left shoulder tenderness, impingement sign is positive right greater than left, right shoulder range of motion is restricted. Reflexes are 2+ and symmetric. There is 4/5 weakness in the right shoulder in abduction, flexion, and internal rotation. The record contains a utilization review determination dated 02/04/14. This document non-certified follow up visits every 4-6 weeks with [REDACTED], drug screen, Terocin pain patch, Ambien 10mg, Terocin 240mL, Flurbi NAP cream 180 grams, and Gabaclyotram 180 grams.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Follow up visits every 4-6 weeks for three months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 357.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-80.

**Decision rationale:** The submitted clinical records indicate that the injured worker sustained a right shoulder injury on 06/29/11. This has resulted in the performance of right shoulder surgery with a revision. The records indicate that the injured worker's condition appears to be static. As such, the request for follow up visits every 4-6 weeks for 3 months is not medically necessary and appropriate.

**Drug screen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77-80, 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-80.

**Decision rationale:** The submitted clinical records indicate that the injured worker has chronically been maintained on oral medication and the performance of a urine drug screen, which is consistent with the California MTUS to assess for compliance. Therefore, the request for a drug screen is medically necessary and appropriate.

**Terocin pain patch box (10patches) #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals Page(s): 105, 112-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

**Decision rationale:** The injured worker has chronic shoulder pain secondary to two prior surgical interventions, however there is insufficient data establishing that the use of this medication has resulted in functional improvements. In the absence of this data, the MTUS guidelines would not support the continued use. Therefore, the request for Terocin 240 ml is not medically necessary and appropriate.

**Ambien 10 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Zolpidem.

**Decision rationale:** The Official Disability Guidelines, state that the use of this medication should be limited to 2-3 weeks until the restoration of a normal sleep pattern has occurred. At that point, this medication should be discontinued. This medication is not indicated for the chronic treatment of sleep disturbance and as such, the request for Ambien 10 mg # 30 is not medically necessary and appropriate.

**Vicodin 5/500mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** It is noted that the injured worker has chronic shoulder pain secondary to 2 prior surgical interventions, however, there is insufficient data establishing that the use of this medication has resulted in functional improvements. In the absence of this data, the request for Vicodin 5/500 mg # 60 is not medically necessary and appropriate.

**Terocin 240 ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105, 112-113.

**Decision rationale:** The injured worker has chronic shoulder pain secondary to 2 prior surgical interventions, however there is insufficient data establishing that the use of this medication has resulted in functional improvements. In the absence of this data, the MTUS guidelines would not support the continued use. Therefore, the request for Terocin 240 ml is not medically necessary and appropriate.

**Flurbi (NAP) cream-la 180 gms:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications and the FDA.

**Decision rationale:** The California MTUS, Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal-compounded medication be approved for transdermal use. This compound contains Flurbiprofen, which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended. Therefore, the request for Flurbi (NAP) cream-la 180 gms is not medically necessary and appropriate.

**Gabacyclotram 180 gms:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications and on the FDA.

**Decision rationale:** The California Medical Treatment Utilization Schedule, Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal-compounded medication be approved for transdermal use. This compound contains Gabapentin and Cyclobenzaprine, which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended. Therefore, the request for Gabacyclotram 180 gms is not medically necessary and appropriate.