

<b>Case Number:</b>	CM14-0126097		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	02/06/2013
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2014

### 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 and Rehabilitation, 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 injured worker is a 54-year-old female who reported an injury on 02/06/2013. The mechanism of injury was not provided. On 07/22/2013 the injured worker presented with right arm pain. Upon examination of the right shoulder the range of motion values were 90 degrees of abduction, 90 degrees of flexion, with 0 degrees of external rotation and 70 degrees of internal rotation. There was tenderness over the right shoulder. The diagnoses were chronic impingement of the right shoulder with type 3 acromion and AC joint arthritis, status post arthroscopic subacromial decompression with postoperative MRI showing type 1 acromion on 04/18/2014, status post Mumford procedure and debridement, frozen shoulder, status post manipulation under anesthesia, loss of consciousness, unclear etiology and radiology report of 8 mm rotator cuff re-tear not confirmed on personal review. The current medication list was not provided. The provider recommended Norco, Naproxen cream, and cyclo/keto/lido cream, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10, one GID PRN #60 with one (1) refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug abuse behavior and side effects. As such, medical necessity has not been established.

**Naproxen cream apply GID PRN 240 gm with one (1) refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 66, 111-113.

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

**Decision rationale:** The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contain at least 1 drug that is not recommended, is not recommended. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics and antidepressants). There is little to no research to support the use of many of these agents. The provider's request does not indicate the site at which the cream was indicated for in the request as submitted. As such, medical necessity has not been established.

**CycloKetoLido cream apply GID PRN 240 gm with one (1) refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contain at least 1 drug that is not recommended, is not recommended. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics and antidepressants). There is little to no research to support the use of many of these agents. The provider's request does not indicate the site at which the cream was indicated for in the request as submitted. As such, medical necessity has not been established.