

<b>Case Number:</b>	CM14-0023879		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	04/07/2011
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	01/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 50-year-old female who reported an injury on 04/07/2011. She was an instructor in a self-defense class, in the process of a demonstration, the other instructor suddenly performed a maneuver, and she was thrown in the air. The clinical note dated 09/11/2013 noted the injured worker presented with tenderness and sensitivity in her left shoulder area, rated at a 6/10 on a pain scale. Upon examination, the patient had tenderness and limited range of motion in her left shoulder. The diagnoses were fracture of the clavicle and pain in the shoulder. Previous treatment included surgery, medications, and therapy. The provider recommended Theraflex cream 180 mg with a quantity of 1, Keratek gel 4 ounces, and retrospective request for left shoulder intra-articular cortisone injection with ultrasound guidance with a date of service of 01/15/2014. The provider's rationale was not provided. The request for authorization 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:

**Keratek gel 4 oz. bottle #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers' Comp, 2012; Work Loss Data Institute, Topical Analgesics, Compounded; Official Disability guidelines, Topical Analgesics.

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

**Decision rationale:** The request for Keratek gel 4 ounces is not medically necessary. Keratek gel is comprised of menthol 16% and methyl salicylate 28%. 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 contains at least one drug that is not recommended is not recommended. The provided documentation did not indicate that the injured worker has failed a trial of antidepressants or anticonvulsants. The provider's request did not indicate the site the gel was intended for. The provider's request did not indicate the dose or frequency of the medication. Therefore, the request is not medically necessary.

**Retrospective request left shoulder intra-articular cortisone injection with ultrasound guidance, DOS 1/15/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 204.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections.

**Decision rationale:** The request for retrospective request left shoulder intra-articular cortisone injection with ultrasound guidance, date of service 01/15/2014, is not medically necessary. The California MTUS/ACOEM state that a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy treatments, such as strengthening exercises and non-steroidal anti-inflammatory drugs, for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. In addition, the Official Disability Guidelines state that anatomical landmarks should guide shoulder injections. The injured worker's diagnosis was a fracture of the clavicle. The included medical documentation did not provide a diagnosis that would be congruent with the guideline recommendations for cortisone injections. There is not enough of an adequate examination of the injured worker providing current deficits to warrant an injection. The rationale for the provider's request of the ultrasound guidance was not provided and use of imaging guidance is not supported by guidelines for shoulder injections. Therefore, the request is not medically necessary.

**Theraflex cream 180mg #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers' Comp, 2012 on the Web ([www.odgtreatment.com](http://www.odgtreatment.com)). Work Loss Data Institute ([www.worklossdata.com](http://www.worklossdata.com), (updated 02/14/12):Topical Analgesics, Compounded; Official Disability Guidelines,Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, and Glucosamine and (Chondroitin Sulfate) Page(s): 111, 50.

**Decision rationale:** The request for Theraflex cream 180 mg with a quantity of 1 is not medically necessary. Theraflex gel is comprised of glucosamine and chondroitin. 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 contains at least one drug that is not recommended is not recommended. The California MTUS Guidelines further state that glucosamine is recommended as an option, given its low risk, in injured workers with moderate arthritic pain, especially for the knee osteoarthritis. For all herbal and dietary supplements, there may be concerns for potential interactions, and with prescription and over-the-counter medications and lack of manufacturing quality controls. Differences in results originate from the difference in products, study design, and study populations. Symptomatic efficacy described in multiple studies performed with glucosamine sulfate support continued consideration in the therapeutic armamentarium. Possible interaction between chondroitin and anticoagulants may be an issue for some injured workers. There is no evidence that the injured worker has intolerance to similar oral medication, or that there was a failed attempt with anticonvulsants or antidepressants. The provider did not indicate dose, frequency, or the site that the cream was intended for. Therefore, the request is not medically necessary.