

Case Number:	CM14-0027771		
Date Assigned:	06/16/2014	Date of Injury:	07/06/2009
Decision Date:	07/16/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/17/2014

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 patient is a 63 year old male who was injured on 07/06/2009. Mechanism of injury is unknown. Prior treatment history has included cortisone injections. There was no other documentation provided of any prior treatment. Progress note dated 12/30/2013 documented the patient with complaints of left shoulder pain rated 6-7/10. He reports increased shoulder pain with all movements and tremors of the hands/fingers with abduction greater than 100 degrees. He reports that he received a cortisone injection that provided no relief. Objective findings on examination of the left shoulder demonstrates limited range of motion due to pain. Left shoulder range of motion is flexion 88/180 degrees, extension 36/50 degrees, abduction 80/180 degrees and adduction 30/50 degrees. The patient was unable to perform internal and external rotation. Impingement test, Hawkins-Kennedy, empty can-supraspinatus and Speed's test are noted positive in the left shoulder. Diagnoses: 1.Left rotator cuff rupture; 2.Status post lumbar fusion at L4-5 with recurrent radiculopathy; 3.Left shoulder acromioclavicular joint osteoarthritis; 4.Rotator cuff tendinosis. Treatment Plan: I am requesting topical creams to reduce pain and decrease the need for oral medications and Medrox patches. Utilization report dated 01/21/2014 the request for Capsaicin/flurbiprofen/tramadol/menthol/camphor/flurbiprofen 25%, cyclobenzaprine 0.2% and Medrox patches was denied because according to the guidelines the efficacy of topical agents are insufficient.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAPSAICIN 0.025%, FLURBIFOFEN 20%, TRAMADOL 15%, MENTHOL 2%, CAMPHOR 2% 240GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Per the MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documented history of neuropathic pain for the shoulder/upper extremity in this case, nor a failed trial of above medications. In addition, the guidelines state that many agents have "little or no research to support the use of many of these agents." Although there are indications noted for topical NSAIDs, lidocaine, capsaicin, and ketamine, there are no current indications for menthol, camphor, or tramadol. As per guidelines "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore, based on the above guidelines and clinical documentation, there is no medical necessity for the requested treatment.

FLURBIPROFEN 25%, CYCLOBENZAPRINE 02% 240GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Per the MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documented history of neuropathic pain for the shoulder/upper extremity in this case, nor a failed trial of above medications. In addition, the guidelines state that "there is little evident to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." As per guidelines "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore, based on the above guidelines and clinical documentation, there is no medical necessity for the requested treatment.

MEDROX PATCHES: 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): 111-113.

Decision rationale: Per the MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documented history of neuropathic pain for the shoulder/upper extremity in this case, nor a failed trial of above medications. In addition, the guidelines state that "there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder," in this case addressing the methyl salicylate component of medroxo patches. As per guidelines "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore, based on the above guidelines and clinical documentation, there is no medical necessity for the requested treatment.