

<b>Case Number:</b>	CM14-0039727		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	01/04/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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 Orthopedic Surgery 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 claimant is a 41 year old male who sustained a vocational injury on 01/04/12 when he was using a battering ram to break down a door. The records provided for review document a working diagnosis of cervical disc syndrome, cervical spine herniated nucleus pulposus, T 7-8 herniated nucleus pulposus of 6 millimeters, right shoulder rotator cuff syndrome, right shoulder supraspinatus tear, frozen shoulder/adhesive capsulitis, bilateral elbow cubital tunnel release, bilateral ulnar nerve compression, lateral epicondylitis, lumbar disc syndrome, lumbar spine herniated nucleus pulposus, gastroesophageal reflux disease, insomnia and anxiety. The report of the 01/20/14 office visit noted complaints of mild right shoulder pain which increased with lifting his arm, and mid and low back pain. On exam, he had slight decreased grip strength of the right hand compared to the left; tenderness on palpation of the subacromial joint of the right shoulder with a positive impingement test. The current request is for TGHOT Topical Cream in 180 gm jar.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FlurFlex topical cream (Flurbiprofen 10%, Cyclobenzaprine 10%) 180 gm jar:** Upheld

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

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

**Decision rationale:** The California MTUS Chronic Pain Guidelines do not support the request for FlurFlex Topical Cream in 180 gm jar. There is a lack of documentation suggesting the claimant has failed traditional first-line medications, such as Tylenol, anti-inflammatories or oral muscle relaxers prior to considering a topical analgesic compound. The Chronic Pain Guidelines state that topical analgesics are considered largely experimental, due to the fact that there are few randomized controlled trials to determine efficacy and safety. Topical analgesics are typically recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, based on the documentation presented for review and in accordance with California Chronic Pain Guidelines, the request for the FluroFlex Cream in 180 gm jar cannot be considered to be medically necessary.

**Lidoderm patches 5% #60:** Upheld

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

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

**Decision rationale:** The California Chronic Pain Guidelines do not support the use of 5% Lidoderm Patches, # 60. According to the California Chronic Pain Treatment Guidelines Lidoderm Patches should be considered for localized peripheral pain, after there has been evidence of a trial first-line therapy. Currently, there is no documentation the claimant has failed traditional first-line conservative treatment options and there is lack of documentation in the form of subjective complaints or abnormal physical exam or objective findings establishing the claimant has localized peripheral pain. Therefore, based on the documentation presented for review and in accordance with California Chronic Pain Guidelines, the request for the Lidoderm Patches 5%, dispensed #60 cannot be considered medically necessary.

**Right shoulder acromioplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The California ACOEM Guidelines do not support the request for right shoulder acromioplasty. There is a lack of documentation that the claimant has failed a traditional course of first-line conservative treatment in the form of at least three to six months on a continuous basis, prior to considering recommending surgical intervention as recommended by ACOEM. In addition, there is a lack of significant reported abnormal physical exam objective findings, establishing medical necessity for the request for surgical intervention. Therefore,

based on documentation presented for review and in accordance with the California MTUS ACOEM Guidelines, the request for the right sholder acromioplasty cannot be considered to be medically necessary.