

Case Number:	CM14-0046396		
Date Assigned:	07/02/2014	Date of Injury:	10/04/2004
Decision Date:	08/22/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/14/2014

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 59-year-old female who reported an unknown injury on 10/04/2004. On 01/31/2014, she presented with pain in her right shoulder and low back. She rated her low back pain as 9/10 and was experiencing bilateral knee pain as well. There was tenderness in the sternoclavicular joint, anterior capsule and acromioclavicular joint of the right shoulder. She has a positive Neer's test, Hawkins maneuver, and impingement sign. Her ranges of motion measured in degrees were abduction 130/180, adduction 30/50, extension 30/50, internal rotation 75/90, external rotation 75/90, and flexion 150/180. Tenderness was present in both knees along with the patellar grind maneuver. She had 0 flexion or extension of her knees. Her diagnoses included cervical hyperextension/hyperflexion, right shoulder rotator cuff tear, bilateral upper extremity overuse tendinopathy, lumbar hyperextension/hyperflexion, status post right shoulder replacement on 04/13/2012, and left knee pain. There was no rationale for the requests included in this chart. The Requests for Authorization dated 01/31/2014 were included in this chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitramadol-DM ultracream 4%/ 20%/10% apply a thin layer to affected area two to three times a day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Guidelines for Topical Use.

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

Decision rationale: The request for amitramadol-DM ultracream 4% / 20% / 10% apply a thin layer to affected area 2 to 3 times a day is non-certified. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control including opioids, local anesthetics, and antidepressants. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. There was no documentation of failed trials of antidepressants or anticonvulsants. The formulation of the requested cream could not be determined. Additionally, the body part to which it was to have been applied was not specified. Furthermore, there was no quantity or frequency of application specified. Therefore, the request for amitramadol-DM ultracream 4% / 20% / 10% apply a thin layer to affected area 2 to 3 times a day is not medically necessary.

Gabaketolido cream 6%/ 20%/ 6.15% cream apply a thin layer to affected area twice daily dose 6 hours apart then withhold for 12 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, Guidelines for Topical Use.

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

Decision rationale: The request for Gabaketolido cream 6%/ 20%/ 6.15% cream apply a thin layer to affected area twice daily dose 6 hours apart then withhold for 12 hours is non-certified. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control including NSAIDs and local anesthetics. There is little to no research to support the use of any of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Ketoprofen is not approved for topical application. It has an extremely high incidence of photo contact dermatitis. Gabapentin is not recommended. There is no peer-reviewed literature to support its use. There was no documentation of failed trials of antidepressants or anticonvulsants. Additionally, no body part to which this cream was to have been applied was specified, nor was there a quantity included in this request. Therefore, this request for Gabaketolido cream 6%/ 20%/ 6.15% cream apply a thin layer to affected area twice daily dose 6 hours apart then withhold for 12 hours is not medically necessary.

Retrospective intramuscular injection of B-12 complex, date of service 1/31/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Vitamin B.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain, Vitamin B.

Decision rationale: The request for Retrospective intramuscular injection of B-12 complex, date of service 1/31/14 is non-certified. The Official Disability Guidelines do not recommend vitamin B. Vitamin B is frequently used for treating peripheral neuropathy, but its efficacy is not clear. In comparison of vitamin B with placebo, there was no significant short-term benefit in pain intensity. There are no lab tests or documentation in the submitted chart to indicate that this injured worker had a vitamin B12 deficiency. She did not have anemia, Crohn's disease, celiac disease, Graves' disease, or lupus. There was no rationale or justification for the use of vitamin B12. It is unknown what benefit the vitamin B12 injection would have on this injured worker's pain level or functional abilities. Therefore, the retrospective request intramuscular injection of B-12 complex, date of service 1/31/14 is not medically necessary.

Continued physical therapy for the right shoulder 2 times a week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 98-99 Page(s): 98-99.

Decision rationale: The request for continued physical therapy for the right shoulder 2 times a week for 6 weeks is non-certified. The California MTUS guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Patients are expected to continue active therapies at home. The physical medicine guidelines allow for a fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The recommended schedule for myalgia and myositis is 9 to 10 visits over 8 weeks. This worker had an unknown number of previous physical therapy visits with no documentation of pain relief or functional improvement. Additionally, the requested 12 sessions of physical therapy exceeds the recommended number of visits in the guidelines. Therefore, this request for continued physical therapy for the right shoulder 2 times a week for 6 weeks is not medically necessary.