

Case Number:	CM14-0083853		
Date Assigned:	08/08/2014	Date of Injury:	10/13/2004
Decision Date:	12/31/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/05/2014

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 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 46 year old female with a date of injury of 10/13/2004. The symptoms include headaches, neck pain, bilateral shoulder pain, right more than left, and low back pain. She underwent anterior cervical discectomy and fusion from C3 to C7 on 3/20/2013. Her clinical diagnosis includes fibromyalgia. The right shoulder pain is severe with a reported pain level of 7/10 to 10/10 on 4/4/2014. An MRI scan of the shoulder dated 4/5/2014 revealed acromioclavicular joint changes and moderate supraspinatus tendinosis but no tear. The labrum and biceps tendon were normal. Clinically she has evidence of impingement with positive Neer and Hawkins-Kennedy testing. The treating physician requested surgery consisting of arthroscopy of the shoulder, subacromial decompression, debridement of supraspinatus tendon, possible rotator cuff repair, and lateral claviclectomy. Additional requests included pre-op clearance, assistant surgeon, cold therapy unit, post-operative physical therapy x 30, right shoulder, transportation, topical flurbiprofen, topical ketoprofen with ketamine, and topical gabapentin/ cyclobenzaprine/ capsaicin. Utilization review certified the surgery, pre-op clearance, and assistant surgeon. The cold therapy was modified to 7 days rental, physical therapy was modified to 12 sessions, and the transportation and all three topicals were non-certified. The date of UR is 5/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-Operative Medical Clearance and Labs to Include CBC (Complete Blood Count) and BMP (Basic Metabolic Panel): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- TREATMENT WORKERS' COMPENSATION LAST UPDATED 5/10/2013 PRE- OPERATIVE TESTING

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Low Back, Topic: Preoperative Testing, General, Preoperative lab testing.

Decision rationale: Pre-op clearance is not in dispute as it was certified by Utilization Review along with the labs including CBC and BMP on 5/28/2014. ODG guidelines indicate necessity of pre-operative lab tests if a positive test will result in appropriate consultations and postponement of surgery until additional work-up is performed.

Cold Therapy Unit (Rental or Purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- TREATMENT WORKERS' COMPENSATION SHOULDER PROCEDURE SUMMARY LAST UPDATED 3/31/2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Continuous Flow Cryotherapy

Decision rationale: California MTUS does not address this issue. ODG guidelines recommend post-operative use of continuous flow cryotherapy for 7 days after shoulder surgery. It reduces swelling, inflammation, and pain and reduces the need for narcotics. Utilization Review has modified the request to a 7 day rental which is consistent with the guidelines. However, the request as stated does not specify the length of rental and also mentions purchase and as such is not medically necessary per evidence-based guidelines.

Post-Operative Physical Therapy, Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 11, 27.

Decision rationale: The postsurgical treatment guidelines recommend 24 visits over 14 weeks for impingement syndrome and rotator cuff repair. The post-surgical physical medicine treatment period is 6 months. The initial course of therapy is 12 visits and with documentation of objective functional improvement a subsequent course of therapy consisting of up to 12 visits may be prescribed within the above parameters. Utilization Review has approved the 12 visits in

accordance with the guidelines. The request for physical therapy as stated does not specify the number of visits and as such is not medically necessary per guidelines.

Prospective Usage of Flurbiprofen 20% gel: Upheld

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

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

Decision rationale: According to the chronic pain guidelines topical analgesics are largely experimental and are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation does not indicate use of anti-epileptics such as pregabalin which is approved for fibromyalgia. The use of topical Flurbiprofen which is an NSAID as requested is not supported by guidelines and as such is not medically necessary. The only FDA approved topical NSAID is diclofenac and its use in widespread pain is not indicated.

Prospective Usage Ketoprofen 20%/ Ketamine 10% Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pregabalin, Ketamine topical, Ketoprofen Page(s): 111, 99, 113, 112.

Decision rationale: Ketoprofen topical is not FDA approved and there is a high incidence of photosensitivity reported. Therefore it is not recommended. Ketamine is recommended for neuropathic pain in refractory cases when all other primary and secondary treatments have been exhausted. Such is not the case here. According to the chronic pain guidelines topical analgesics are largely experimental and are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation does not indicate use of anti-epileptics such as pregabalin which is approved for fibromyalgia. The use of topical analgesics as requested is not supported by guidelines and as such is not medically necessary.

Prospective Usage Gabapentin 10%/ Cyclobenzaprine 10%/ Capsaicin 0.0375%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Gabapentin and Cyclobenzaprine Page(s): 28, 113.

Decision rationale: Capsaicin, topical is recommended as an option in patients who have not responded or are intolerant to other treatments. The documentation does not suggest lack of response or intolerance to other drugs. Cyclobenzaprine and Gabapentin are supported as oral

agents but not as a compounded topical agents. There is no evidence for use of any of the muscle relaxants as a topical product. Gabapentin topical is not recommended per guidelines. Therefore the request for Gabapentin, Cyclobenzaprine, and Capsaicin topical is not medically necessary per guidelines.