

Case Number:	CM14-0087542		
Date Assigned:	08/08/2014	Date of Injury:	02/13/2013
Decision Date:	09/16/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/11/2014

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 patient is a 59 year old male who sustained an industrial injury on 2/13/2013. According to the 3/6/2014 PR-2, the patient's complaint is left shoulder pain, and objective finding is + impingement signs. Diagnosis is left shoulder impingement. A cortisone injection was administered to left shoulder subacromial space, with 10% pain relief. According to the most recent PTP PR-2, dated 7/22/2014, the patient's chief complaints are cervical spine, lumbar spine, bilateral shoulders, and bilateral wrist and hand pain. He complains of persistent pain rated 7/10, unchanged from prior visit. He continues to have radiation of pain into the bilateral upper extremities and right leg. Pain is improved with rest and medication. He takes Motrin, which reduced pain from 8 to 4/10. He is not currently working. Examination of the left shoulder reveals limited ROM with 150 degrees flexion, 40 degrees extension, 150 degrees abduction, 40 degrees adduction, 50 degrees internal rotation, and 60 degrees external rotation. Neer's and Hawkin's impingement tests are positive, painful arc of motion beyond 115 degrees, 4+/5 muscle strength with flexion, abduction and external rotation. Diagnosis of the left shoulder is left shoulder rotator cuff tear and rotator cuff syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Subacromial Decompression, Repair Versus Debridement:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for impingement syndrome.

Decision rationale: According to the CA MTUS/ACOEM Guidelines, lesions of the rotator cuff are a continuum, from mild supraspinatus tendon degeneration to complete ruptures. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. The guidelines state "surgery for impingement syndrome is reserved for cases failing conservative therapy for three months." Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. Conservative treatment has results similar to surgical treatment but without surgical risks. According to the Guidelines, surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. The medical records do not provide a thorough documentation of the patient's past treatment history for the left shoulder. As such, it is not established that the patient has failed and exhausted non-operative care for this complaint. In addition, it is not clear that the patient has significant loss of function with the left shoulder, so as to persistently impact or impede his ADLs. In addition, the medical records do not include diagnostic evidence of a surgical lesion, such as on an MRI. Given these factors, the medical records fail to establish the requested surgery is medically necessary.

Post Op Physical Therapy Left Shoulder 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DME - Polar Care 7 Day Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Shoulder Sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Postoperative abduction pillow sling.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Kera Tek Gel 4 Oz: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Salicylate topicals Page(s): 111-113,105.

Decision rationale: The CA MTUS guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. According to the guidelines, topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. Regarding non-steroidal anti-inflammatory agents (NSAIDs), the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The Keratek gel is a topical compound containing menthol 16% and methyl salicylate 26% topical analgesic. The medical records do not provide a rationale for using this product as opposed to supported alternatives that are already FDA approved and available OTC. The request for Keratek Gel 4 oz. is not medically necessary.

Theraflex - Flurbiprofen/Cyclobenzaprine/Menthol Cream 180 Gm: 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: The CA MTUS Guidelines state "topical analgesics are considered largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Regarding non-steroidal antiinflammatory agents (NSAIDs), the efficacy in clinical trials for this treatment modality has

been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." This compound also contains Cyclobenzaprine, a central muscle relaxant, which is not recommended as there is no evidence of using any other muscle relaxant as a topical product. The guidelines state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore, in accordance with the guidelines, the request for Theraflex-Flurbiprofen/Cyclobenzaprine/Menthol Cream 180gm is not medically necessary.