

Case Number:	CM14-0089544		
Date Assigned:	07/23/2014	Date of Injury:	09/19/2013
Decision Date:	08/27/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/13/2014

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:

This 51-year-old male sustained an industrial injury on 9/19/13. The mechanism of injury was not documented. The 1/7/14 right shoulder MRI impression documented severe thinning, full-thickness or near full-thickness tearing, or possibly avulsion of the distal anterior supraspinatus tendon at the greater tuberosity attachment. There was deformity and osseous prominence ridging of the anterolateral aspect of the greater tuberosity. There was possible myxoid change and ganglion cyst or interstitial tearing within the remaining supraspinatus tendon. The patient was status post lumbar decompression and anterior fusion with posterior instrumentation at L4/5 on 2/12/14. The 5/16/14 treating physician report cited constant grade 7/10 bilateral shoulder pain radiating to the upper extremities. There was associated popping and clicking. Physical exam documented range of motion testing with flexion 120, internal rotation 45, and external rotation 45 degrees. Hawkin's and Neer's tests were positive. Drop arm test was positive. Supraspinatus strength was 4/5. The diagnosis included right shoulder subacromial impingement syndrome with full-thickness rotator cuff tear. Surgery was recommended to include right shoulder arthroscopy, subacromial decompression, and rotator cuff repair. Additional requests included assistant surgeon, internal medicine clearance, cold therapy unit, post-op physical therapy, transportation, and topical creams. The 6/3/14 utilization review certified the request for right shoulder arthroscopy with subacromial decompression and rotator cuff repair. The request for post-operative physical therapy x 30 sessions was modified to 12 sessions consistent with post-surgical treatment guideline recommendations for initial care. The request for transportation to and from the facility was denied as there was no rationale substantiating this request. The requests for topical cream were denied in the absence of guideline support for all compounded products.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST OPERATIVE PT X 30 SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 6/3/14 utilization review recommended partial certification of 12 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request for post-operative PT x 30 sessions is not medically necessary.

TRANSPORTATION TO AND FROM FACILITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines transportation to and from facilities.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Transportation (to & from appointments).

Decision rationale: The California MTUS does not specifically address the medical necessity of transportation. The ACOEM state that nonmedical issues should be managed by the provider. These issues can be handled in the same way as a regular medical specialist referral, using a network of resources when non-medical issues are involved. The Official Disability Guidelines state that transportation to and from appointments is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. There is no rationale provided to support the medical necessity of this request. There is no documentation that the patient has a disability preventing self-transport or securing a ride. Therefore, this request for transportation to and from facility is not medically necessary.

FLURBIPROFEN 20% CREAM 120GM: 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 California MTUS guidelines do not recommend topical non-steroid anti-inflammatory drugs (NSAIDs), like Flurbiprofen, for neuropathic pain and state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine or shoulder. Guideline criteria have not been met. Specific indications for the use of this topical cream are not provided. Use in the shoulder is not supported by guidelines. Therefore, this request for Flurbiprofen 20% cream 120gm is not medically necessary.

KETOPROFEN 20%, KETAMINE 10% CREAM 120GM: 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 California MTUS guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state that Ketoprofen is not currently FDA-approved for topical application due to an extremely high incidence of photocontact dermatitis. The topical use of Ketamine is under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request for Ketoprofen 20%, Ketamine 10% cream 120gm is not medically necessary.

GABAPENTIN 10% CYCLOBENZAPRINE 10% CAPSAICIN 0.0375% CREAM 120GM: 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 California MTUS state that any compounded product that contains at least one drug that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The topical use of Gabapentin is not recommended by guidelines. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Capsaicin is supported as an option in patients who have not responded or are intolerant to other treatments. Given the absence of guideline support for all components of this

product, this product is not recommended by guidelines. Therefore, this request for Gabapentin 10% Cyclobenzaprine 10% Capsaicin 0.0375% cream 120gm is not medically necessary.