

Case Number:	CM15-0142208		
Date Assigned:	08/03/2015	Date of Injury:	05/15/2013
Decision Date:	09/03/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 52 year old male, who sustained an industrial injury on May 15, 2013 while working at a lumber company. The injury occurred when the injured worker was struck on the left side of the head with a board causing him to fall backwards and down a flight of stairs. The injured worker landed on his right side. He experienced immediate neck and right shoulder pain. The injured worker sustained 4 fractures of the right shoulder. The diagnoses have included cervical discogenic radiculopathy, cervical spine sprain-strain, right shoulder rotator cuff tear, right shoulder biceps tendinopathy, right shoulder bursitis, right shoulder acromioclavicular joint degenerative joint disease, right shoulder capsulitis, right shoulder superior labrum, anterior to posterior tear, right shoulder impingement syndrome, mid back pain and headaches. Treatment and evaluation to date has included medications, radiological studies, MRI, physical therapy, chiropractic treatments, acupuncture treatments, injections, extracorporeal shockwave therapy and an anterior cervical fusion. The injured worker was noted to be temporarily totally disabled. Current documentation dated June 10, 2015 notes that the injured worker reported constant achy neck pain and intermittent right shoulder pain. The pain was rated a 7 out of 10 on the visual analogue scale. Examination of the cervical spine revealed tenderness to palpation with spasm over the paravertebral muscles and range of motion revealed a decreased right lateral bending. A Spurling's maneuver was negative. Right shoulder examination revealed tenderness to palpation of the anterior shoulder. There were spasms noted over the lateral shoulder. Orthopedic testing including a Neer's test, Hawkin's test and shoulder apprehension test were negative. The treating physician's plan of care included requests for one right shoulder mini open rotator cuff repair and

arthroscopic subacromial decompression, 12 sessions of post-operative physical therapy, Amitriptyline 10%-Gabapentin 10%-Bupivacaine HCL 5%-Hyaluronic acid 0.2% in a cream base 240 gm and Flurbiprofen 20%-Baclofen 5%-Camphor 2%-Menthol 2%-Dexamethasone micro 0.2%-Capsaicin 0.025%-Hyaluronic acid 0.2% in a cream base.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) right shoulder mini open rotator cuff repair and arthroscopic subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery.

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

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case weak or absent abduction is not noted, nor is relief from anesthetic injection. The request is not medically necessary.

12 sessions of post op physical therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Amitriptyline 10%/Gabapentin 10%/Bupivacaine HCL 5%/Hyaluronic acid 0.2% in cream base 240 gm: 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(s): 111.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended for topical use. Therefore the request is not medically necessary.

Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone micro 0.2%/Capsaicin 0.025%/Hyaluronic acid 0.2% in cream base: 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(s): 111.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Diclofenac is the only FDA approved topical NSAID. Other NSAIDs have a high rate of photosensitive reactions and are not recommended. Therefore the request is not medically necessary.