

Case Number:	CM15-0142456		
Date Assigned:	08/03/2015	Date of Injury:	07/15/2014
Decision Date:	09/03/2015	UR Denial Date:	07/11/2015
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, North Carolina
 Certification(s)/Specialty: Family Practice

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 47 year old male who sustained an industrial/work injury on 7-15-14. He reported an initial complaint of shoulder pain. The injured worker was diagnosed as having rotator cuff tear, s/p shoulder debridement, sub-acromial decompression, and rotator cuff repair on 2-5-15. Treatment to date includes medication, surgery, and physical therapy. MRI of shoulder results were reported on 8-13-14 demonstrated complete tear of the supraspinatus, partial tear of the anterior fibers of the infraspinatus, severe degenerative changes of the AC (acromioclavicular) joint indents the supraspinatus, and small joint effusion. X-ray results were reported on 1-27-15 of chest due to chest pain that was negative. Currently, the injured worker complained of pain in right upper extremity rated 5 out of 10 associated with weakness and popping in shoulder. Per the primary physician's report (PR-2) on 4-14-15, exam does full range of motion with forward flexion and internal rotation, extension at 10 degrees, manual muscle testing is 4 out of 5. The requested treatments include Retrospective Ortho Nestic gel dispensed on 4/14/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ortho Nestic gel dispensed on 4/14/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

Decision rationale: CA MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, Ortho Nescic gel is requested. This gel is an over-the-counter formulation containing menthol and camphor. There is no scientific evidence that either active component in this gel has any therapeutic benefit. Therefore, this request is deemed not medically necessary or appropriate.