

Case Number:	CM15-0185638		
Date Assigned:	10/07/2015	Date of Injury:	08/06/2013
Decision Date:	12/15/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/21/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65-year-old female who sustained an industrial injury on 8-6-2013. Diagnoses have included left shoulder adhesive capsulitis and status post left shoulder surgery with residual tendinosis and interstitial tear. An MRI dated 10-3-2014 showed residual tendinosis and interstitial tear. Documented treatment includes left shoulder surgery 6-2-2014. She has attended physical therapy with requests for 12 additional sessions noted 5-13-2015 and 6-2-2015 totaling at least 24 completed sessions. Physical therapy note dated 8-3-2015 reports that goal of the injured worker becoming independent with home exercise program was met, however, ability to participate in light activities, increasing shoulder strength and range of motion were still "in progress." It is noted that the injured worker reported improvement in left shoulder pain, motion, and strength, but still finds reaching difficult. Medications referenced in the documentation are the requested topical creams noted to be prescribed "in order to minimize possible complications of opioid use and upper GI bleeding." There are no opioid medications noted in the documentation. At the 8-5-2015 visit, the injured worker reported continued neck and left shoulder pain being 6 out of 10 which is stated to have increased from 4 out of 10 at the last visit. Objective examination noted grade 2 tenderness over cervical and left shoulder muscles and restricted range of motion at both sites. A cervical compression test was noted as positive, and with the left shoulder, impingement and supraspinatus tests were positive, which is stated to have been the same. It is noted in the physical therapy note that the injured worker remains temporarily totally disabled. In the 8-5-2015 progress note, the treating physician's plan of care includes Trepadone #120 "for one month"; Flubi Nap Cream which is a compound of

Flurbiprofen, Lidocaine and Amitriptyline; 12 additional sessions of physical therapy; a urine drug screen; and, a Depo Medrol injection was administered. These were denied on 9-8-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trepadone #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Compensation, Trepadone.

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

Decision rationale: Trepadone is a medical food. It may be recommended for individuals with certain cardiovascular or lipid conditions, for the treatment of rheumatoid arthritis, and/or for depressed individuals who cannot take conventional antidepressants. Specifically, as it pertains to medical food per ODG, it is not recommended based on additional evidence of adverse effects. Medical food is defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) as a "food which is formulated to be consumed or administered entirely under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." Medical foods do not have to be registered with the FDA and as such are not typically subject to the rigorous scrutiny necessary to allow recommendation by evidence-based guidelines. There is no clear reason for this prescription, and no mention of nutritional deficiency to warrant certifying the request for Trepadone given the cited conditions. This request is not medically necessary.

Flurbi(Nap) cream 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or antidepressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is no mention of previous failure to traditional agents for neuropathic pain including anticonvulsants/antidepressants. Furthermore, this requested agent contains topical Lidocaine and Amitriptyline. Amitriptyline is not supported by MTUS for topical use. As such, this request is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Compensation, Pain Procedure Summary, Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

Decision rationale: According to the California MTUS Drug Screening section, Chronic Pain 2009 Guidelines, urine drug screening can be considered to monitor for abuse in those who are taking high risk, addictive narcotic pain medications. There is no clear mention of high risk for abuse, or history of abusing drugs in this injured worker to warrant a UDS. As such, this request is not medically necessary.

5CCs of 1% Xylocaine, 1CC of 40mg of Depo Medrol: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Procedure Summary, Criteria for Steroid Injections.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative management for 2 or 3 weeks. Official Disability Guidelines support subacromial injections for adhesive capsulitis, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, or when pain interferes with functional activities. ODG-TWC notes that a second injection is not recommended if the first injection has led to complete resolution of symptoms or if there was no response to the first injection. Within the records, there is noted date of injury 08/2013 with previous injections performed using a subacromial approach. However, there is no mention of previous response (including pre and post injection VAS pain scores, and/or mention of functional response to include ADLs) to the past injection to warrant consideration for a repeat injection. As such, this request is not medically necessary.

Additional physical therapy x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The California MTUS recommends 8-10 sessions of physical therapy for various myalgias or neuralgias. Guidelines recommend fading of treatment frequency with ultimate transition to a home exercise program. ODG Guidelines recommend six visit clinical trials of physical therapy, and close monitoring of tolerance and progress to determine if the individuals are making positive gains, no gains, or negative response to therapy. There have been more than 40 completed sessions of physical therapy for the cited injuries. There is no reason why the injured worker cannot continue to progress utilizing a self-directed home exercise program. The guideline recommendations have already been grossly exceeded. This request is not medically necessary.