

<b>Case Number:</b>	CM15-0023228		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	03/13/2014
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 30-year-old female who reported an injury on 03/13/2014. The mechanism of injury was not specifically stated. The current diagnoses include right shoulder pain, right deltoid/biceps tendonitis, and rotator cuff supraspinatus tendonitis. The injured worker presented on 01/29/2015 for a follow-up evaluation. The injured worker reported 2/10 pain. It was noted that the injured worker was utilizing ibuprofen. Upon examination, there was unrestricted range of motion of the cervical spine, tenderness at the right trapezii and supraspinatus area, tenderness at the levator scapulae area, deltoid and biceps tenderness, mild crepitus of the shoulder, tenderness over the flexor digitorum superficialis and flexor carpi radialis, tenderness with palpation over the thenar area, 75% of normal bilateral shoulder range of motion, full range of motion of the bilateral wrists, 5/5 motor strength in the bilateral upper extremities, and 2+ deep tendon reflexes. Recommendations at that time included acupuncture treatment and an MRI of the shoulder. A Request for Authorization form was then submitted on 01/29/2015 for Asprean gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat MRI of the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 207-209.

**Decision rationale:** California MTUS/ACOEM Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, there was no documentation of a significant musculoskeletal or neurological deficit. There was no mention of a progression or worsening of symptoms or physical examination findings. The medical necessity for a repeat imaging study has not been established in this case. As such, the request is not medically appropriate.

**Asperein Gel, #1 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): (s) 105, 111-112.

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. In this case, there was no documentation of a failure of first line oral medication prior to the initiation of a topical analgesic. The request as submitted also failed to indicate a frequency. Therefore, the request is not medically necessary.