

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0042610 | | |
| Date Assigned: | 03/12/2015 | Date of Injury: | 09/18/1999 |
| Decision Date: | 04/15/2015 | UR Denial Date: | 02/27/2015 |
| Priority: | Standard | Application Received: | 03/06/2015 |

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
Certification(s)/Specialty: Emergency Medicine

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 57 year old female, who sustained an industrial injury on 9/18/1999. The mechanism of injury and initial complaint was not provided for review. The injured worker was diagnosed as status post rotator cuff repair. Treatment to date has included home exercises and medication management. Currently, a medication refill request from 1/15/2015 was provided for review and the most recent progress note from the treating provider dated 6/2/2014 indicates the injured worker reported needed medication refill and prior nausea and vomiting.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 01/15/15) Ultracin lotion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: The requested Retrospective (DOS: 01/15/15) Ultracin lotion, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic

pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The injured worker is s/p rotator cuff repair. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Retrospective (DOS: 01/15/15) Ultracin lotion is not medically necessary.