

Case Number:	CM15-0050754		
Date Assigned:	03/24/2015	Date of Injury:	10/27/2011
Decision Date:	05/04/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/17/2015

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: Minnesota, Florida

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 57 year old male, who sustained an industrial injury on 10/27/2011. He has reported subsequent neck, shoulder and right foot pain and was diagnosed with cervical, bilateral shoulder and right foot sprain and bilateral shoulder rotator cuff tears. Treatment to date has included oral and topical pain medication, application of heat, home strengthening exercises and surgery. In a progress note dated 01/21/2015, the injured worker complained of bilateral shoulder pain that was rated as 8-9/10. Objective findings were notable for tenderness of the cervical paravertebrals and trapezius, bilateral AC joint and subacromial space, decreased range of motion and a slightly antalgic gait. Neer and Hawkin's signs were positive on the left but not the right side. Requests for rotator cuff repair, Flexeril and FLFCMK cream were made. Utilization Review referenced a prior approval of the open rotator cuff surgery for the left shoulder in December 2014. There was no documentation indicating that surgery had been performed. The surgical request for the right shoulder was to be addressed after reviewing the results of such surgery on the left side. The additional request for flexeril was noncertified using MTUS chronic pain guidelines. The GLFCMK cream was noncertified using MTUS chronic pain guidelines. These are now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery for rotator cuff repair of the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211.

Decision rationale: In December 2014 utilization review modified a request for bilateral open rotator cuff repairs to certify a left shoulder open rotator cuff repair. The reasoning was to review the IWs response to left shoulder surgery prior to further consideration for the right shoulder surgery. The MRI scan of the left shoulder, performed on 4/17/2014 revealed a full-thickness rotator cuff tear measuring 1.5 x 1.3 cm at the anterior supraspinatus insertion, superimposed upon significant partial tearing of the supraspinatus tendon. There was moderate tendinopathy of the infraspinatus and subscapularis tendons. Mild anatomic impingement related to a downsloping acromion was noted. Degenerative signal was noted in the superior labrum. An MRI of the right shoulder dated April 17, 2014 revealed a small full-thickness tear of the distal supraspinatus tendon superimposed upon significant partial thickness tearing with rotator cuff tendinopathy involving the supraspinatus and infraspinatus tendons. There was suggestion of a partial thickness tear of the bursal surface of the distal infraspinatus tendon. A report by the orthopedic surgeon dated December 8, 2014 documented failed physical therapy multiple times. The plan was for left shoulder rotator cuff repair first and then the right shoulder cuff repair after. The utilization review certified a left shoulder rotator cuff repair on December 31, 2014. The right shoulder was not certified at that time to allow a review of the patient's response to the left shoulder surgery prior to further consideration for the right shoulder rotator cuff repair. The documentation indicates that despite the certification, the left shoulder surgery has not been performed. The surgical procedure will be followed by postsurgical rehabilitation of the shoulder. The right shoulder surgery cannot be performed until the left shoulder postsurgical rehab is completed to allow for performance of activities of daily living. The status of the right shoulder at that future date is not currently known and it is not certain if CA MTUS guideline criteria for the right shoulder will be present at that time. The guidelines do not indicate surgery for mild symptoms or those patients whose activities are not limited. The progress notes do not document impingement signs in the right shoulder per records referenced above. As such, the request for left shoulder surgery is supported; however, the medical necessity for the right shoulder surgery cannot be determined at this time.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics: Cyclobenzaprine Page(s): 64.

Decision rationale: With regard to the request for Flexeril California MTUS chronic pain guidelines indicate Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. As such, the request for chronic use of Cyclobenzaprine is not supported and the medical necessity has not been substantiated.

GLFCMK cream, #60gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111, 112, 113.

Decision rationale: With regard to the request for topical GLFCMK cream, this is a compounded drug containing gabapentin, lidocaine, flurbiprofen, cyclobenzaprine, menthol, ketamine, and ultraderm. California MTUS chronic pain guidelines indicate topical analgesics are largely experimental in use. Gabapentin is not recommended. Ketamine is only recommended for treatment of neuropathic pain and refractory cases in which all primary and secondary treatment has been exhausted. Flurbiprofen is not currently FDA approved for topical application. Only Voltaren is approved. Any compounded product that contains at least one drug that is not recommended is not recommended. As such, the request for topical GLFCMK cream is not supported and the medical necessity of the request has not been substantiated.