

Case Number:	CM15-0086154		
Date Assigned:	05/08/2015	Date of Injury:	06/16/2013
Decision Date:	06/18/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/05/2015

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: 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 63 year old male who sustained an industrial injury to his left shoulder on 06/16/2013. The mechanism of injury was not documented. The injured worker was diagnosed with left shoulder adhesive capsulitis and cervical disc protrusion. The injured worker is status post left shoulder surgery (no date documented). Treatment to date includes diagnostic testing with cervical magnetic resonance imaging (MRI) in August 2014, shoulder surgery, physical therapy and medications. According to the primary treating physician's progress report on April 15, 2015, the injured worker continues to experience left shoulder and neck pain. Examination documented positive impingement left shoulder and tenderness to palpation at C3 through C7. No further detail was included. Current medications are listed as Tramadol and Naprosyn. Treatment plan consists of the current request for X-ray and Computed Tomography (CT) of the left shoulder and Zostrix cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zostrix Cream 60gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients, which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.

CT scan of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: The ACOEM chapter on shoulder complaints, Table 9-6 summary of recommendations states: Radiography indicated for acute AC joint separations with stress films. MRI recommended for preoperative evaluation of partial thickness or large full thickness rotator cuff tears. MRI is not recommended for evaluation without surgical indications. Criteria for imaging have not been met and the request is not medically necessary.

X-ray of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: The ACOEM chapter on shoulder complaints, Table 9-6 summary of recommendations states: Radiography indicated for acute AC joint separations with stress films. MRI recommended for preoperative evaluation of partial thickness or large full thickness rotator cuff tears. MRI is not recommended for evaluation without surgical indications. Criteria for imaging is not met through the provided clinical documentation and therefore the request is not medically necessary.