

Case Number:	CM14-0090807		
Date Assigned:	07/23/2014	Date of Injury:	09/11/2010
Decision Date:	09/22/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/16/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient has a reported industrial injury on 9/11/10. Panel QME from 1/17/14 reports Patient has full range of motion with abduction and flexion of the shoulders to 180 degrees. Report states that there is no point tenderness at the biceps groove, subacromial bursae or AC joint. Impingement sign is negative bilaterally. Exam notes 3/4/14 reports complaints of right shoulder pain. Report is made of cortisone injection to the right shoulder in December 2013, which provided one-week relief. Report is made of completion of 24 session of physical therapy without improvement. Right shoulder range of motion is noted to be from 120 degrees of flexion on the right. 4/8/14 report demonstrates positive impingement signs and decreased range of motion. Request made for compounding cream consisting of Tramadol, Gabapentin, Capsaicin, Flurbiprofen and Cyclobenzaprine. MRI of the right shoulder from 7/7/13 demonstrates a partial rotator cuff tear with chronic tendinosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. There is a significant discrepancy between the Panel QME from 1/17/14 and the exam notes by the requesting physician from 3/4/14 and 4/8/14. In addition night pain and weak or absent abduction must be present which has not been demonstrated. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. As the criteria referenced have not been satisfied and there is discrepancy in range of motion in the cited records, the determination is for non-certification.

PT x 8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, the determination is for non-certification for PT x 8 visits.

Compound creams: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-112 Page(s): 111-112.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, page 111-112 "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. 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." Therefore the determination is for non-certification.