

<b>Case Number:</b>	CM15-0014792		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	12/17/2006
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 64-year-old female who reported an injury on 12/17/2006 due to an unspecified mechanism of injury. On 12/19/2014, she presented for a followup evaluation. She reported left shoulder pain that was persistent and constant, rated at a 6/10 to 7/10. She also stated that she was having difficulty with range of motion. She was noted to be taking lisinopril and "other medications" that she stated were helping. A physical examination showed that she had an intact gait and there was no evidence of a surgical incision or scar on the left shoulder. Swelling was present and ecchymosis was absent, and there was absent erythema. There was tenderness to palpation in the sternoclavicular joint and anterior capsule and acromioclavicular joint. There was no instability noted, and range of motion was noted to be decreased in the left shoulder. There was also crepitation noted on range of motion and strength was a 4/4 bilaterally. She was diagnosed with status post open reduction and internal fixation fracture, chronic regional shoulder girdle myofascial pain, and left shoulder adhesive capsulitis. The treatment plan was for Ultram 50 mg #60 with 3 refills and topical medications. The rationale for treatment was to treat the injured worker's symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50 mg # 60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the left shoulder. However, there is a lack of documentation showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate compliance, and 3 refills of this medication would not be supported without a re-evaluation of the injured worker to determine treatment success. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Ketoprofen/Gabapentin/Diclofenac/Lidocaine Cream 15/8/5/5% 120 gm:** 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): 111-114.

**Decision rationale:** The California MTUS Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical Gabapentin, baclofen, and muscle relaxants are not supported by the guidelines for use. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the left shoulder. However, there is a lack of documentation showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, the compound cream contains medications that are not supported for topical use. Furthermore, there is a lack of evidence showing that she has tried and failed recommended oral medications, and the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Flurbiprofen/Baclofen/Cyclobenzaprine Cream 20/2/2% 120 gm:** 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): 111-114.

**Decision rationale:** The California MTUS Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical, baclofen, and muscle relaxants are not supported by the guidelines for use. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the left shoulder. However, there is a lack of documentation showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, the compound cream contains medications that are not supported for topical use. Furthermore, there is a lack of evidence showing that she has tried and failed recommended oral medications, and the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.