

<b>Case Number:</b>	CM15-0091634		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	09/17/2009
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 50 year old man sustained an industrial injury on 9/17/2009. The mechanism of injury is not detailed. Diagnoses include cervical spine herniated nucleus pulposus and impingement syndrome of the right shoulder. Treatment has included oral medications. Physician notes dated 3/31/2015 show complaints of bilateral shoulder pain with radiation to the bilateral upper extremities rated 6-8/10 and constant right wrist and hand pain rated 8/10. Recommendations include right shoulder MRI, topical compounded cream, and urine drug testing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 10%, Cyclobenzaprine 10% Capsaicin 0.0375% 120 gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208, Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

**Decision rationale:** Regarding the request for Gabapentin 10%, cyclobenzaprine 10%, and Capsaicin 0.0375%, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." Therefore, topical compound cream containing gabapentin is not medically necessary.

**Flurbiprofen 20% 120 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208, Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112.

**Decision rationale:** Regarding the request for topical flurbiprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, the provider ordered 2 different compound creams one with Flurbiprofen and the other with Ketoprofen on the same date without providing rationale of why this is clinically indicated. Furthermore, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, as he was tolerating Voltaren in 2014 without documented side effects. In the absence of clarity regarding those issues, the currently requested topical flurbiprofen is not medically necessary.

**Ketoprofen 20%/Ketamine 10% cream 120 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208, Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

**Decision rationale:** Regarding the request for topical Ketoprofen 20% and Ketamin 10% cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, the provider ordered 2 different compound creams one with Flurbiprofen and another with Ketoprofen on the same date without providing rationale of why this is clinically indicated. Furthermore, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, as he was tolerating Voltaren in 2014 without documented side effects. In the absence of clarity regarding those issues, the currently requested topical Ketoprofen with Ketamine is not medically necessary.

**Magnetic Resonance Imaging (MRI) of the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Magnetic resonance imaging (MRI).

**Decision rationale:** Regarding the request for MRI of the right shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 4 to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines further specify imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, it does not appear the patient has failed conservative treatment options. Furthermore, it is unclear how an MRI will change the patient's current treatment plan, as there were no significant pathology on exam and no red flag symptoms to warrant an MRI of the shoulder at this time. In the absence of clarity regarding those issues, the currently requested right shoulder MRI is not medically necessary.