

# US Decisions Inc.

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**DATE NOTICE SENT TO ALL PARTIES:** May/03/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Baclofen POW, Flurbiprofen POW, Amitriptylin POW Hel, Propylene glycol solution, salt stable cream LS adv - left shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for Baclofen POW, Flurbiprofen POW, Amitriptylin POW Hel, Propylene glycol solution, salt stable cream LS adv - left shoulder is not established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was injured on XX/XX/XX when he injured the left shoulder pushing an object. The patient sustained a full thickness tear of the rotator cuff and required a mini open repair on XX/XX/XX. The patient was referred for postoperative physical therapy. The patient was followed by XX postoperatively for continuing left shoulder pain. The XX/XX/XX clinical report noted persistent pain, numbness, tingling and weakness in the left shoulder. This was aggravated by lifting. No significant improvement had been obtained with medications such as ibuprofen or hydrocodone as well as physical therapy. The patient was utilizing hydrocodone 5/325 mg every 6 to 8 hours for pain and Advil 200 mg. No side effects for medications were noted. The physical exam did note limited abduction to 160 degrees and forward elevation was normal at 180 degrees. The patient was recommended to continue with physical therapy. The compounded medication in question to include baclofen, flurbiprofen and amitriptyline was denied by utilization review as there was limited evidence to support the use of these medications topically.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for continuing complaints of left shoulder pain despite surgery and postoperative physical therapy as well as medication use. Current evidence based guidelines to include ODG pain guidelines does not recommend the use of compounded medications in which the intended components are considered experimental and investigational or not FDA approved for transdermal use. In this case, the requested components include baclofen, Flurbiprofen, and amitriptyline which are not FDA approved for transdermal use and have limited evidence in the current literature regarding their efficacy in a transdermal compounded medication. Furthermore, the records have not identified any contraindications to the use of oral medications including the oral version of the requested components of the compounded medication. As the clinical documentation provided for review does not meet guideline

recommendations for the requested compounded medication, it is this reviewer's opinion that medical necessity for Baclofen POW, Flurbiprofen POW, Amitriptylin POW Hel, Propylene glycol solution, salt stable cream LS adv - left shoulder is not established and the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)