

Case Number:	CM13-0025176		
Date Assigned:	03/14/2014	Date of Injury:	10/31/2010
Decision Date:	05/02/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	09/16/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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 is a 41 year female who was injured on 10/31/2010 while she was moving a number of trays weighing about 35 pounds with bread on them to cooling vats when she had pain. Prior treatment history has included the patient undergoing right shoulder arthroscopic surgery on 07/14/2012. The patient uses IF 4 unit at home for pain symptoms. Diagnostic studies reviewed included an MRI of the right shoulder dated 09/14/2010 revealing mildly narrowed substrates outlet secondary to laterally downsloping acromion and prominent coracoacromial ligament, which may predispose to impingement. Trace amount of subacromial bursal fluid is present, possibly bursitis. Consider tendinosis at the supraspinatus tendon and distal infraspinatus tendon. MRI of the lumbar spine dated 09/14/2010 revealed right-ward deviation of the upper lumbar spine maybe positional in nature or due to mild dextroscoliosis. L5-S1 shows mild degenerative disc disease. There is L5-S1 mild dis bulging which is mildly indenting on the ventral thecal sac. No neural foraminal narrowing is appreciated. There is no change on the flexion and extension images. MRI of the cervical spine dated 09/14/2010 revealed C6-C7 shows mild disc desiccation with a 2 mm central and right paracentral disc protrusion mildly impressing on the ventral sac. No neural foraminal narrowing is appreciated. No changes seen on flexion/extension views. Progress note dated 11/27/2013 the patient to have complaints of bothering pain. She takes anti-inflammatories and Neurontin. Objective findings on exam included no evidence of Homer's. She has both supraclavicular and infracalicular plexus tenderness. Neural tension signs, radial ulnar and median nerves are positive. She is normoflexic and she does not have positive Hoffman.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDOCAINE PATCH 5% QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Indication Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm® (Lidocaine Patch), Page(s): 56-57.

Decision rationale: The guidelines state topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. However, the medical records do not establish this patient has localized peripheral pain. EMG/NCV studies performed of the bilateral upper and lower extremities revealed normal findings, with no evidence of neuropathy. Furthermore, the progress note dated 11/27/2013 states the patient was taking Neurontin and anti-inflammatories for bothersome pain, however, there is no subjective report or objective findings consistent with neuropathy present. The request for Lidocaine patches is not medically necessary under the guidelines, and the request is non-certified.

NAPROSYN 500 MG QTY: 60.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs, Page(s): 67-68.

Decision rationale: Given the documented subjective complaints and objective findings, it is reasonable that the patient be provided with a non-steroidal anti-inflammatory to provide symptomatic relief of mild to moderate pain. The medical records document the patient has been using anti-inflammatory to address pain. There are no documented issues of side-effects with use. This request is supported by the reference guidelines and therefore is certified.

CHIROPRACTIC EVALUATION AND TREATMENT QTY: 4.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

Decision rationale: According to the CA MTUS, chiropractic is recommended for chronic pain if caused by musculoskeletal conditions. The medical records do not thoroughly detail the patient's prior treatment history. It is not documented whether the patient has undergone

chiropractic treatment in the past, and if so, her response to treatment. The 11/27/2013 progress report does not demonstrate the existence of the clinically significant functional deficits and abnormal findings on examination. The medical records do not establish the patient has presented with a recent flare-up or exacerbation and had failed to respond to a recent trial with a home exercise program, NSAIDs and palliative measures such as ice/heat and activity modification. The patient has been recommended Naprosyn, it would be appropriate to assess the patient's response to this intervention, prior to considering in further treatment measures. Therefore the request is non-certified.

REFER TO RHEUMATOLOGIST QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

Decision rationale: The guidelines states the clinician provides appropriate medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The medical records do not document subjective complaints with correlating clinical findings or observations that would support a need for a rheumatology referral. The subjective complaints, objective examination and radiographic findings do not substantiate any rheumatologic pathology. In the absence of supportive evidence regarding the request, the medical necessity is not substantiated. The request is not supported by the guidelines. Therefore the request is non-certified.

FUNCTIONAL CAPACITY EVALUATION (FCE) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004) , CHAPTER 7, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, PAGE 137-138

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 21,81.

Decision rationale: The medical records do not establish that a functional capacity evaluation is medically indicated for the management of this patient. There are no documented failed return-to-work attempts, conflicting medical reporting on precautions or fitness to perform modified job duties, or that she has injuries that require detailed exploration of her abilities. In addition, the patient is not a candidate for a work hardening program. Consequently, the medical necessity of a functional capacity evaluation has not been established. A FCE is not supported by the evidence-based guidelines, and therefore the request is non-certified.

WORK CONDITIONING PROGRAM (AFTER COMPLETION OF FCE) QTY: 12.00:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning Page(s): 125.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning , Work Hardening Page(s): 125-126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Work Conditioning, Work Hardening.

Decision rationale: The ODG state Work Conditioning amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation do not preclude concurrently being at work. The request for WC of 12 sessions exceeds the maximum number recommended under the guidelines. Furthermore, the medical records do not detail the patient's treatment history, status post right shoulder arthroscopic surgery on 07/14/2012. The medical records do not establish the patient requires additional and more intensive physical therapy. The medical records do not establish that this patient is a viable candidate for work conditioning. Therefore the request is non-certified.