

<b>Case Number:</b>	CM14-0014775		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 Occupational 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 52-year-old male who has submitted a claim for L5-S1 herniated nucleus pulposus with first degree spondylolisthesis and spondylosis of L5 bilaterally, degenerative disc disease of L3-L4, L4-L5 and L5-S1, right testicular pain, left carpal tunnel syndrome, left shoulder impingement, status post left shoulder subacromial decompression and partial distal claviclectomy, status post left carpal tunnel release and status post lumbar decompression of L4 through S1 and fusion of L5-S1 associated with an industrial injury date of August 20, 2012. Medical records from 2013-2014 were reviewed. The patient complained of left shoulder and low back pain, rate 5/10 in severity. He cannot sleep on his left shoulder and has pain on reaching behind over his head. The back pain goes into the left buttock. Physical examination showed tenderness on the scapular region. There was limited range of motion as well. Straight leg raise test was positive bilaterally. Motor and sensation was intact. MRI of the left shoulder, dated October 31, 2012, revealed SLAP tear and a partial supraspinatus tendon tear. MRI of the lumbar spine, dated November 2, 2012, showed degenerative disc and facet joint disease, and bilateral L5 spondylosis resulting in 4-5mm L5-S1 anterolisthesis. Treatment to date has included medications, physical therapy, chiropractic therapy, pool therapy, home exercise program, activity modification, lumbar decompression and fusion surgery, and left shoulder subacromial decompression. Utilization review, dated February 3, 2014, denied the requests for 1 MRI of the left shoulder arthrogram, 1 X-force with solar care for shoulder, and 1 prescription of Gabapentin 300mg #60. Reasons for denial were not made available.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 MRI OF THE LEFT SHOULDER ATHROGRAM: Overturned**

**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): 208,557-559.

**Decision rationale:** As stated on page 208 of the ACOEM Guidelines referenced by CA MTUS, imaging studies are supported for: emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. Pages 557-559 state that MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. MRI is more sensitive and may be the preferred investigation because it demonstrates soft tissue anatomy better. Subtle tears that are full thickness are best imaged by arthrography, whereas larger tears and partial-thickness tears are best defined by MRI. Conventional arthrography can diagnose most rotator cuff tears accurately; however, in many institutions MR arthrography is usually necessary to diagnose labral tears. In this case, patient complained of persistent left shoulder pain. MRI of the left shoulder dated October 31, 2012 showed SLAP tear and partial supraspinatus tendon tear. Another MRI of the left shoulder was being requested to see what may be causing the continued pain. MRI with an arthrogram may be necessary to enhance sensitivity, especially in diagnosing subtle labral tears that may be causing the persistent pain. Therefore, the request for 1 MRI of the Left Shoulder Athrogram is medically necessary.

## **1 X-FORCE WITH SOLAR CARE FOR SHOULDER: 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 Transcutaneous electrotherapy, TENS, chronic pain (transcutaneous electrical nerve stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Section, Infrared Therapy.

**Decision rationale:** Regarding X Force, it is noted to be a TENS unit as well as a transcutaneous electrical joint stimulation unit. As stated on pages 114-116 of the California MTUS Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as the primary treatment modality but a one-month trial may be considered if used as an adjunct to a program of evidence-based functional restoration given that conservative treatment methods have failed and that a specific treatment plan with short and long term goals has been established. The California MTUS, Official Disability Guidelines, and peer-reviewed literature do not address transcutaneous electrical joint stimulation. With regards to solar care, CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that infrared therapy is not

recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, the patient had persistent left shoulder pain. The rationale of the present request was not provided. It was also not mentioned if the request would be a one-month home-based trial. In addition, there was no documentation regarding failure of other ongoing treatment modalities or medications being used. A treatment plan concerning the use of the unit was also not found in the documentation. Also, there is no discussion regarding the necessity for a combination electrotherapy unit. Regarding Solar care, guidelines are silent with regard to the use of infrared therapy for the shoulders. In addition, the patient is not in the acute phase of treatment. There was also no documentation of a specific conservative treatment which would act as an adjunct for the infrared heating system. Therefore, the request for 1 X-Force With Solar Care for Shoulder is not medically necessary.

**1 PRESCRIPTION OF GABAPENTIN 300 MG #60: Overturned**

**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 Anti-Epilepsy Drugs Page(s): 16-19.

**Decision rationale:** According to pages 16-19 of CA MTUS Chronic Pain Medical Treatment Guidelines, Gabapentin has been considered as a first-line treatment for neuropathic pain. The patient should be asked at each visit as to whether there has been a change in pain or function. In this case, the patient was being started on Gabapentin to see if nerve pain on his back and shoulder would be reduced. The patient has low back pain that goes to his left buttock. Physical examination finding showed positive straight leg raise test. Gabapentin is an appropriate treatment option at this time. Therefore, the request for 1 Prescription Of Gabapentin 300 Mg #60 is medically necessary.