

Case Number:	CM14-0130182		
Date Assigned:	08/18/2014	Date of Injury:	12/06/2010
Decision Date:	09/26/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/14/2014

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 Family Practice and is licensed to practice in Texas and Mississippi. 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 injured worker is a 60-year-old male who reported an injury on 12/06/2010, due to sustaining cumulative trauma to his hands, elbows, shoulders, knees, legs, neck and lower back. The injured worker complained of neck pain, severe bilateral shoulder pain, bilateral hand and wrist pain, bilateral elbow pain, severe bilateral knee pain. The diagnoses included bilateral shoulder impingement with post-traumatic arthritis, bilateral elbow post-traumatic arthritis, ulnar nerve entrapment bilaterally chronic and severe, bilateral ulnar nerve palsy with hand atrophy bilaterally, bilateral medial meniscus tears and early post-traumatic arthritis of the knees, cervical spine strain/sprain and massive left shoulder rotator cuff tear. The past surgical procedures included a left status post carpal tunnel release dated 07/29/2011, status post subtotal menisci chondroplasty of the medial compartment of the left knee and synovectomy of the left knee dated 06/10/2011. The MRI of the left shoulder dated 02/14/2014, revealed some motion degradation artifact, joint effusion, anterior and posterior capsules indicating capsulitis and sprain, fluid in the subcapularis bursa, acromion type 2, concave undersurface, arthrosis of the acromioclavicular joint, fluid within the acromioclavicular joint, intrinsic impingement of the transversing underlying supraspinatus, thinning and retraction of the supraspinatus tendon, consistent with full thickness tear, and several 1 mm to 3 mm cysts versus varicose veins in the spinoglenoid notch. The diagnostics included electromyogram and x-ray. The past treatments included medication, physical therapy and a knee brace. The objective findings dated 07/22/2014 of the left shoulder revealed flexion of 80 degrees and abduction of 70 degrees with a 4/4 pain on the left shoulder with positive impingement, Neer's and Hawkin's tests bilaterally and positive adduction tests. Hand grip on the left was 13/13/13. The medications included tramadol 150 mg, Prilosec 20 mg, Norflex 100 mg, and Xanax 1 mg, topical creams that include ketoprofen, gabapentin and tramadol. The treatment plan included an MRI and medication. The Request for

Authorization was not submitted with documentation. The rationale for the MRI and medication was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 9 Shoulder Complaints, pages 207-209. The Expert Reviewer's decision rationale: The California MTUS/ACOEM indicates that "routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears should be treated the same as impingement syndrome regardless of magnetic resonance imaging (MRI) findings. Shoulder instability can be treated with stabilization exercises; stress radiographs simply confirm the clinical diagnosis." The guidelines indicate that stabilization exercises should be encouraged. As such, the request is not medically necessary.

Pharmacy purchase: Tramadol/ Gabapentin/ Ketoprofen: 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 Analgesic, Lidocaine Page(s): 111, 112.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesic, Lidocaine, pages 111, 112. The Expert Reviewer's decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety, are primarily recommended for neuropathic pain when trials of antidepressants and when anticonvulsants have failed. MTUS states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines indicate that "topical Lidocaine (Lidoderm) 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). No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Gabapentin is not recommended." There is no peer-reviewed literature to support use. The guidelines indicate that if one compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. The request did not address the frequency, dosage or duration. As such, the request is not medically necessary.