

<b>Case Number:</b>	CM14-0177980		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	04/11/2008
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 39-year-old male with a date of injury of 04/11/2008. The listed diagnoses per [REDACTED] are: 1. Partial thickness rotator cuff tear, 2. Derangement of knee, 3. Neck pain, 4. Adhesive capsulitis of shoulder, 5. Severe major depression, single episode, 6. Knee pain, 7. Brachial plexus disorder, 8. Shoulder joint pain. According to progress report, 10/17/2014, the patient presents with right shoulder, right arm, and right hand pain. There is radiation of pain to the right side of the neck and head. Present pain score was noted as 8/10. Examination revealed the joint swelling of the right shoulder and throughout the arm. There was stiffness and tenderness in the right shoulder joint and muscle spasms noted in the right side of the neck and right scapula. Weakness noted in right upper extremity. The patient's pain is alleviated with ice and medication. With moderate assistance from others, she is able to bathe. She is dependent on others for driving, housekeeping, cooking, and shopping. The patient is status post arthroscopy of the right knee in 2003 and status post ORIF for recurrence subluxation, right patella, in 2004. Utilization Review denied the request on 10/24/2014. Treatment reports from 02/17/2014 through 10/17/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 aquatic therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines recommends aquatic therapy Page(s): 22.

**Decision rationale:** This patient presents with continued complains of upper extremity weakness and pain. The treater recommends 6 aquatic therapy sessions. The treater states that the patient has not tried aqua therapy in the past and he would like a course to "help with pain and improve strength in the neck." The MTUS Guidelines page 22 recommends aquatic therapy as an option for land-based therapy in patients that could benefit from decreased weight bearing such as extreme obesity. For number of treatments, the MTUS Guidelines page 98 and 99 recommends for myalgia and myositis type symptoms, 9 to 10 sessions over 8 weeks. In this case, the treater is requesting aquatic therapy sessions to improve strength in the patient's neck. MTUS recommends aquatic therapy for patient's with weight bearing restrictions. Such is not documented; therefore, recommendation is for denial.

**Gastroenterology consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Standards Practice Task Force of the American Society of Colon and Rectal Surgeons. Practice parameters for the surgical treatment of ulcerative colitis. Dis Colon Rectum. 2014 Jan

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127 consultations

**Decision rationale:** This patient presents with continued upper extremity complaints. The treater is requesting a gastroenterologist consultation. The treater states in his 10/17/2014 report that patient "remains in F/U with a GI specialist once a month for ulcerative colitis." ACOEM Practice Guidelines, second edition (2004), page 127 has the following, "the occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." In this case, the treater has noted that the patient is already following up on a monthly basis with a GI specialist for ulcerative colitis. The request appears duplicative. The treater does not explain whether or not a second opinion is being sought. Recommendation is for denial.

**Home health aide (8 hours a day, 5 days a week for 6 weeks):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Chronic Medicare Benefits Manual, Chapter 7, Home Health Services. Section 50.2 (Home Health Aide Services)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines home services Page(s): 51.

**Decision rationale:** This patient presents with continued upper extremity complaints. The treater is requesting home health aid (8 hours a day, 5 days a week for 6 weeks). Treater states that the patient's "wife was previously paid to take care of him in his home as this requires considerable effort on her part to take care of, which does not allow her to work outside the home." The MTUS page 51 has the following regarding home services, "recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis generally up to no more than 35 hours per week." In this case, there are no significant physical findings that would require a home health care aide. There are no discussions regarding the patient's specific functional needs that would require assistant and the medical justification for the deficits. MTUS recommends home health care assistant for patients that require medical treatment and that are homebound. There is no discussion indicating that the patient is homebound or that other medical care is needed in the home. Recommendation is for denial.

**Lidoderm 5% patch (700mg/patch):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Lidoderm® (lidocaine patch)

**Decision rationale:** This patient presents with upper extremity complaints. The request is for Lidoderm 5% patch (7 mcg/patch). Progress reports indicate that the patient has been utilizing Lidoderm patches since at least 04/14/2014. The treater reports the Lidoderm patches are used nightly and patient "notes 40% reduction of pain with the use of topical medications without adverse effects." MTUS guidelines page 57 states, "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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain. Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the patient has knee pain but it is not neuropathic pain. The patient does not meet the indication for these patches and therefore this request is not medically necessary.

**Pennsaid 1.5% topical drops:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** This patient presents with continued upper extremity complaints. The treater is requesting Pennsaid 1.5% topical drops. Review of the medical file indicates the patient has been utilizing this topical cream since 04/14/2014. Pennsaid is an NSAID. The MTUS Guidelines allows for the use of topical NSAID for peripheral joint arthritis and tendonitis. Although this patient is noted to have knee pain, the treater states that Pennsaid is being utilized for localized pain symptoms for patient's "adhesive capsulitis of the shoulder." MTUS states, "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." Recommendation is for denial.