

<b>Case Number:</b>	CM14-0034184		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/12/2004
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2014

### 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 Orthopaedic Surgery 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:

This 64-year-old female manufacturing supervisor sustained an industrial cumulative trauma injury. The date of injury was 2/12/04. Past medical history was positive for multiple surgeries including bilateral carpal tunnel releases in 2004 and 2005, left shoulder surgery in 2007, right shoulder surgery in 2009, right long finger surgery in 2011, and right rotator cuff repair 3/25/13. The 11/5/13 left shoulder MRI (magnetic resonance imaging) impression documented curved lateral downsloping acromion, mild supraspinatus and infraspinatus tendinosis, biceps tendon partial tear, Superior Labrum from Anterior to Posterior Tear (SLAP) type I/II tear, and anterior and posterior labral tears. The 12/17/13 treating physician report cited grade 8/10 left shoulder pain. Left shoulder exam findings documented rotator cuff muscle tenderness, range of motion limited by pain, and positive impingement tests. There was global left upper extremity 4+/5 weakness. The 1/28/14 treating physician appeal letter cited left shoulder pain, especially with lifting. Physical exam findings documented left shoulder flexion/abduction 100 degrees, extension 38 degrees, adduction 40 degrees, and internal/external rotation 60/60 degrees. Rotator cuff compression test was positive on the left. The treatment plan recommended left shoulder arthroscopic debridement of the labral tear and left shoulder acromioplasty. The records indicated that the patient had undergone bilateral shoulder cortisone injections with reported relief. Prior physical therapy with home exercise program to the shoulders was reported. The 2/24/14 utilization review denied the request for left shoulder surgery and associated services based on an absence of failed conservative treatment and lack of clear guideline support for surgical intervention in Type I/II SLAP lesions. Lidoderm patches were denied as there was no clear indication of neuropathic pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE (1) LEFT SHOULDER ARTHROSCOPIC DEBRIDEMENT OF THE LABRAL TEAR AND LEFT SHOULDER ACRMIOPLASTY: 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), Shoulder (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for SLAP lesions, Surgery for impingement syndrome.

**Decision rationale:** Under consideration is a request for left shoulder arthroscopic debridement of the labral tear and acromioplasty. The California MTUS guidelines do not address surgeries for chronic shoulder injuries. The Official Disability Guidelines (ODG) states that SLAP (Superior Labrum from Anterior to Posterior Tear) lesions may warrant surgical treatment in certain cases, and arthroscopic repair of extensive tears can achieve good outcomes. Surgical intervention may be considered for patients failing conservative treatment. The ODG surgical criteria for acromioplasty require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. The ODG criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for 3 to 6 months and had failed. There is an indication of prior physical therapy (more than one year ago) but no documentation of recent care specifically focused on the left shoulder to improve strength or range of motion. There is no documentation of compliance with a home exercise program. Slight global left upper extremity weakness is noted, but no specific functional shoulder weakness. Therefore, this request for left shoulder arthroscopic debridement of the labral tear and left shoulder acromioplasty is not medically necessary.

**ONE (1) PRE-OP MEDICAL CLEARANCE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

**Decision rationale:** Since the primary procedure (left shoulder arthroscopic debridement of the labral tear and left shoulder acromioplasty) is not medically necessary, none of the associated services (pre-op medical clearance) are medically necessary.

**TWELVE (12) POST-OP PHYSICAL THERAPY VISITS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** Since the primary procedure (left shoulder arthroscopic debridement of the labral tear and left shoulder acromioplasty) is not medically necessary, none of the associated services (twelve post-op physical therapy visits) are medically necessary.

**ONE (1) PRESCRIPTION OF LIDODERM PATCHES, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** Under consideration is a request for one prescription of Lidoderm patches #30. The California MTUS indicates that Lidoderm patches may be recommended for localized peripheral pain after evidence of a trial of first-line neuropathic therapy (tri-cyclic or norepinephrine reuptake inhibitor (SNRI) anti-depressants or an anti-epileptic drug (AED) such as gabapentin or Lyrica). Continued outcomes should be intermittently measured and if improvement cannot be determined or does not continue, lidocaine patches should be discontinued. The MTUS guidelines criteria have not been met. There is no indication that this patient has neuropathic pain that is being treated with Lidoderm patches. There is no documentation of outcome measures relative to the use of these patches as required by guidelines. In the absence of documented improvement, discontinuation is recommended. Therefore, this request for one prescription of Lidoderm patches #30 is not medically necessary.