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| <b>Case Number:</b>   | CM14-0041802 |                              |            |
| <b>Date Assigned:</b> | 06/30/2014   | <b>Date of Injury:</b>       | 03/28/2005 |
| <b>Decision Date:</b> | 07/30/2014   | <b>UR Denial Date:</b>       | 03/26/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/09/2014 |

### 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 Orthopedic 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 male sustained an industrial injury on 7/18/05, relative to cumulative trauma. The 11/5/13 MRI documented degenerative change at the acromioclavicular (AC) joint that has progressed with a new inflammatory arthropathy. There is mild tendinopathy of the distal supraspinatus that may be exacerbated by degenerative change at the AC joint. There is no full thickness tear. Conservative treatment included over-the-counter anti-inflammatory medications, TENS unit, home exercise, analgesics, and muscle relaxants. On-going requests for therapy are noted, but there is no evidence of therapy in the records provided since 2012. The 3/5/14 treating physician report cited constant aching sensation in the shoulders that gets worse with colder weather. X-rays of both shoulders showed no acute changes. Physical exam findings documented 90 degrees abduction, 110 degrees flexion, painful arc, positive impingement, and no gross instability. The diagnosis was right shoulder sprain with possible internal derangement, and left shoulder sprain with impingement syndrome. The treatment plan recommended over-the-counter Tylenol, Lidocaine patches, physical therapy or chiropractic 3x6, and bilateral shoulder arthroscopy. The 3/26/14 utilization review did not grant the request for shoulder arthroscopy as the patient did not meet guideline criteria. The request for Lidoderm patches was denied based on a failure to meet guideline indications relative to diagnosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Shoulder Arthroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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 impingement syndrome.

**Decision rationale:** The California MTUS does not provide recommendations for surgery in chronic shoulder complaints. The Official Disability Guidelines state that surgery for impingement syndrome is usually acromioplasty. The ODG provide indications for acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement is required. Guideline criteria have not been met. There is no documentation that recent physical medicine treatment directed toward gaining full range of motion had been tried and failed. There is no documentation of a positive diagnostic injection test. There is no documentation of muscle strength. There is no clear imaging evidence of impingement. Therefore, this request for shoulder arthroscopy is not medically necessary.

**Prospective request for Unknown prescription of Lidocaine patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics (Lidocaine) Page(s): 112.

**Decision rationale:** The California MTUS indicates that Lidoderm (lidocaine) patches may be recommended for localized peripheral pain after evidence of a trial of first-line neuropathic therapy (tri-cyclic or SNRI anti-depressants or an 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. Guideline 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 evidence of a trial of first-line neuropathic therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Therefore, this prospective request for an unknown prescription of Lidocaine patches is not medically necessary.