

Case Number:	CM15-0132472		
Date Assigned:	07/20/2015	Date of Injury:	10/26/2010
Decision Date:	08/25/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 52-year-old male with an industrial injury dated 10/26/2010. Her diagnoses included cervicalgia with left upper extremity radiculopathy, bilateral shoulder pain status post right shoulder rotator cuff repair, bilateral shoulder rotator cuff tears, shoulder pain and lumbago. Prior treatment included cervical spine surgery, shoulder surgery, physical therapy and diagnostics. She presents on 06/08/2015 with complaints of bilateral shoulder pain, neck pain and low back pain. Physical findings included cervical and bilateral shoulder range of motion was decreased. MRI of the left shoulder dated 02/11/2015 showed partial thickness bursal surface and intra substance interstitial tear in distal supraspinatus and infraspinatus tendons without full thickness tear or retraction. The provider documents the injured worker has expressed concern about ongoing use of Ibuprofen causing her stomach upset. The provider notes Lidoderm patches are being requested instead of oral anti-inflammatories. The treatment request is for left shoulder arthroscopy with rotator cuff debridement versus repair and Medi-patch with Lidoderm #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medi-patch with lidoderm #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 56-57.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57, regarding 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, the exam notes from 3/6/15 and 3/8/15 demonstrates there is no evidence of failure of first line medications such as gabapentin or Lyrica. Therefore, the request for lidoderm patches is not medically necessary.

Left shoulder arthroscopy with rotator cuff debridement versus repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally, there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case, the submitted notes from 3/16/15 and 6/8/15 do not demonstrate 4 months of failure of activity modification and dedicated physical therapy program. Nor does this documentation demonstrate history of night pain or relief from anesthetic injection. Therefore, the requested procedure is not medically necessary.