

<b>Case Number:</b>	CM15-0192788		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	06/30/2012
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 66 year old female, who sustained an industrial injury on 6-30-12. The injured worker was diagnosed as having cervical spondylosis without myelopathy, adhesive capsulitis of shoulder and rotator cuff sprain and strain. Medical records (6-2-15 through 7-20-15) indicated 6 out of 10 pain at worst and 5 out of 10 pain on average and temporarily totally disabled. The physical exam (6-23-15 through 7-20-15) revealed "reduced" cervical range of motion, tenderness at C7-T1 bilaterally and a positive Hawkin's and Neer's test in the left shoulder. As of the PR2 dated 8-17-15, the injured worker reports pain in her neck and shoulders. She rates her pain 6 out of 10 at worst and 5 out of 10 on average. She describes the pain as aching, numbness, throbbing, tingling and soreness. Objective findings include "reduced" cervical range of motion, tenderness at C7-T1 bilaterally and a positive Hawkin's and Neer's test in the left shoulder. Current medications include Meloxicam, Nabumetone, Omeprazole, Gabapentin, Duloxetine and LidoPro (since at least 4-28-15). Treatment to date has included a left shoulder MRI on 3-28-13 showing moderate subscapularis tendinosis, left shoulder rotator cuff surgery on 8-6-14 and physical therapy for the left shoulder (from at least 12-8-14 through 3-20-15). The treating physician requested LidoPro 4.5%-27.5%-0.0325%-10% Topical ointment for 2 tubes and a suprascapular nerve block. The Utilization Review dated 9-9-15, non-certified the request for LidoPro 4.5%-27.5%-0.0325%-10% Topical ointment for 2 tubes and a suprascapular nerve block.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**LidoPro 4.5%-27.5%-0.0325%-10% Topical ointment for 2 tubes:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The patient was injured on 06/30/12 and presents with left shoulder pain and neck pain. The request is for LidoPro 4.5%-27.5%-0.0325%-10% Topical ointment for 2 tubes. The RFA is dated 09/15/15 and the patient is temporarily totally disabled. LidoPro lotion contains capsaicin, lidocaine, menthol, and methyl salicylate. Regarding topical analgesics, MTUS Guidelines page 111 has the following regarding topical cream, "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least 1 (or 1 drug class) that is not recommended is not recommended." The patient has a limited cervical spine range of motion, tenderness at C7-T1 bilaterally, and a positive Hawkin's and Neer's test in the left shoulder. She is diagnosed with cervical spondylosis, adhesive capsulitis of shoulder and rotator cuff sprain and strain. MTUS Guidelines do not allow any other formulation of lidocaine other than in patch form. MTUS Guidelines do not recommend a compounded product if one of the compounds are not indicated for use. Since lidocaine is not indicated for this patient in a non-patch form, the entire compound is not recommended. Therefore, the requested LidoPro ointment IS NOT medically necessary.

**Suprascapular nerve block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, under Nerve Blocks.

**Decision rationale:** The patient was injured on 06/30/12 and presents with left shoulder pain and neck pain. The request is for Suprascapular nerve block. The RFA is dated 09/15/15 and the patient is temporarily totally disabled. MTUS chronic pain guidelines did not discuss shoulder injections. MTUS/ACOEM states; Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy. But does not discuss suprascapular injections. ODG guidelines were consulted. ODG-TWC guidelines, Shoulder Chapter, under Nerve Blocks has the following: "Recommended as indicated below. Suprascapular nerve block is a safe and efficacious treatment for shoulder pain in degenerative disease and/or arthritis. It improves pain, disability, and range of movement at the shoulder compared with placebo. The use of bupivacaine suprascapular nerve blocks was effective in reducing the pain of frozen shoulder at one month, but not range of motion. Suprascapular nerve blocks have produced faster and more complete resolution of pain and restoration of range of movement than a series of intra-articular injections. According to this systematic review, there was moderate evidence for the effectiveness of suprascapular nerve block compared with

acupuncture, placebo, or steroid injections for pain relief. The suprascapular nerve block is a reproducible, reliable, and extremely effective treatment method in shoulder pain control. Arthroscopy-guided suprascapular nerve block at the end of a rotator cuff repair is safe. Suprascapular nerve block is a safe and effective treatment for patients with hemiplegic shoulder pain. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response." ODG states these are performed without ultrasound guidance. The patient has a limited cervical spine range of motion, tenderness at C7-T1 bilaterally, and a positive Hawkin's and Neer's test in the left shoulder. She is diagnosed with cervical spondylosis, adhesive capsulitis of shoulder and rotator cuff sprain and strain. The 09/14/15 report states that the patient had 2 previous left shoulder surgeries the last one approximately one year ago in August 2014. The patient's MRI from April 15, 2014 shows evidence of acromioplasty and mini Mumford procedure. She continues to have significant tenderness at the humeral joint both anteriorly and posteriorly. The patient has tendinosis of the supraspinatus, infraspinatus, subscapularis, and biceps tendon. She has global shoulder tenderness and pain which affects her function. Her abduction is approximately 70 [degrees] and her flexion is approximately 80 [degrees]. In this case, the patient does not present with degenerative disease and/or arthritis of the shoulder for which suprascapular nerve injection may be indicated per ODG guidelines. Therefore, the request IS NOT medically necessary.