

<b>Case Number:</b>	CM15-0202232		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	01/07/2014
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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, Oregon, Washington  
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, who sustained an industrial injury on 1-7-14. The injured worker has complaints of left shoulder pain. Examination of the shoulders revealed there is minimal tenderness over the anterior left shoulder and range of motion for left shoulder for flexion, extension, abduction, internal rotation and external rotation was decreased. The diagnoses have included rotator cuff (capsule) sprain. Treatment to date has included norco and physical therapy. Magnetic resonance imaging (MRI) in April 2014 revealed impingement in the left shoulder. The original utilization review (9-17-15) modified the request for physical therapy for the left shoulder, 1 time a week for 8 weeks, quantity 8 sessions to quantity 2. The request for flurbiprofen 20%, lidocaine 5%, #1 and left shoulder steroid injection with ultrasound guidance, quantity 1 were denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left shoulder, 1 time a week for 8 weeks, quantity: 8 sessions:**  
Upheld

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

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

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98-99 recommend the following for non-surgical musculoskeletal conditions, Physical Medicine Guidelines, Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. In this case, the note from the orthopedic surgeon, 8/15/14 states that there has been no surgical intervention nor is one planned. This case thus far is a nonoperatively treated case. As the total number of completed physical therapy visits and the requested physical therapy exceeds the recommendation, the determination is not medically necessary.

**Flurbiprofen 20%/Lidocaine 5%, #1: 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): Lidoderm (lidocaine patch), Topical Analgesics.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the current request does not meet CA MTUS guidelines and therefore the request is not medically necessary. 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 provided demonstrates there is no evidence of failure of first line medications such as gabapentin or Lyrica. Additionally this patient does not have a diagnosis of post-herpetic neuralgia or neuropathic pain. Therefore, the request is not medically necessary and non-certified.

**Left shoulder steroid injection with ultrasound guidance, quantity: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder / Steroid injections.

**Decision rationale:** Per ODG, Shoulder/Steroid injections: "Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three." In this case, the proposed injection is requested to be under ultrasound guidance. The ODG guidelines specifically state that this injection is performed without fluoroscopic or ultrasound guidance. Review of the medical records provided do not show that the shoulder pain interferes with functional activities. Thus, this patient does not meet ODG guidelines and the recommendation is not medically necessary.