

Case Number:	CM15-0046315		
Date Assigned:	03/18/2015	Date of Injury:	06/28/2014
Decision Date:	04/23/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/11/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 42-year-old female, who sustained an industrial injury on 6/28/2014. She reported a lifting injury, resulting in right shoulder pain. The injured worker was diagnosed as having shoulder tenosynovitis, rotator cuff tear, status post surgical repair, and adhesive capsulitis. Treatment to date has included surgical (10/23/2014 right rotator cuff repair) and conservative measures. Currently, the injured worker complains of constant right shoulder pain with interference with activities of daily living. Current medications included Flexaril at bedtime as needed. She reported instruction to stop using nonsteroidal anti-inflammatory drugs due to a thin esophagus lining. Physical exam noted no acute distress. Her right shoulder was diffusely tender to palpation. Active range of motion was decreased in all planes. Sensation was intact. Motor exam noted weakness, with restricted abduction, internal, and external rotation, due to pain. A positive impingement sign was documented. She was offered and accepted a right glenohumeral cortisone injection (2/11/2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care x12 on the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chiropractic care Page(s): 58-59.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care not medically necessary. Recurrences/flare-ups Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended, Forearm, Wrist, & Hand: Not recommended, Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However, the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 12 sessions. This does not meet criteria guidelines and thus is not medically necessary.

Lidopro Cream 121gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

Decision rationale: The California chronic pain medical treatment guidelines section on topical lidocaine states: Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007, the FDA notified

consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) Non-neuropathic pain: Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudds, 1995) This medication is recommended for localized peripheral pain. There is no documentation of failure of first line neuropathic pain medications. There is no neuropathic pain diagnosis. Therefore, criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.

Retrospective Glenohumeral Cortisone Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation <http://www.odg-twc.com/odgtwe/shoulder.htm>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202-205.

Decision rationale: The ACOEM chapter on shoulder complaints states that glenohumeral joint injections be performed under fluoroscopic guidance. Injections in the subacromial space may be performed in the office: If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. Therefore, the request is not medically necessary.

RTC 2 weeks for depression screening: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Stress.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

Decision rationale: The ACOEM chapter on general approach does recommend routine follow up visits in the care of patients with chronic pain. In this instance, the request is for depression screening though there is no indication of significant depression symptoms or why a follow up visit for depression screening would be necessary versus simple depression screening questionnaire tools. Therefore, the request is not medically necessary.

Diclofenac Sodium ER 100mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines, Non-selective NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 63-73.

Decision rationale: The California chronic pain medical treatment guideline section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side effects or risk factors. The dosage prescribed is within recommendations .Therefore the request is medically necessary.