

Case Number:	CM15-0083372		
Date Assigned:	05/05/2015	Date of Injury:	01/14/2014
Decision Date:	06/25/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/30/2015

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, Pain Management

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 42 year old female sustained an industrial injury to the right foot, left shoulder and low back on 1/14/14. Previous treatment included x-rays, physical therapy and medications. Lumbar spine x-rays showed some degenerative disc disease and a small degenerative spondylolisthesis. Magnetic resonance imaging left shoulder (2/5/15) showed sub deltoid bursitis, mild supraspinatus and infraspinatus tendinitis and/or strain without evidence of rotator cuff tear. In a PR-2 dated 3/5/15, the injured worker complained of ongoing left shoulder, low back and right foot pain. The injured worker was working modified duty. Physical exam was remarkable right foot with tenderness to palpation over the right foot and heel and left shoulder with positive impingement and O'Brien tests. The injured worker could heel and toe walk and forward flex and extend her back. Motor strength was 5/5 to bilateral lower extremities. The injured worker had a protuberant abdomen with weak abdominal muscles. Current diagnoses included left shoulder pain, left shoulder impingement, left shoulder rotator arthropathy, lumbago without radiculopathy including spondylolisthesis and right foot plantar fasciitis. The treatment plan included left shoulder steroid injection with Lidocaine, Marcaine and Kenalog under ultrasound guidance, additional physical therapy (12 sessions) for core strengthening and home strengthening exercises for the right foot. In an appeal of denial dated 4/1/15, the injured worker requested an ergonomic workstation evaluation and adjustment. The injured worker reported that her workstation could be improved to prevent further aggravation of her condition. The physician was appealing the denial of physical therapy for the lumbar spine, noting that the injured worker did not feel that she had the opportunity for full benefit of therapy to the lumbar

spine as it was divided amongst three body parts (lumbar spine, left shoulder and right foot). The physician was also appealing the denial of left shoulder injection noting that the injured worker's left shoulder pain persisted and that physical therapy had only provided relief while the injured worker was attending. The physician also requested topical compound cream Flurbiprofen 10/5-Cyclobenzaprine 1%-Gabapentin 6%-Lidocaine 2%-Prilocaine 2% in Lidoderm Activemax #1 with 5 refills as an adjunct to pain management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ergonomic workstation evaluation and adjustment per 04/01/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 6.

Decision rationale: Regarding the request for workstation ergonomic evaluation and adjustment, Occupational Medicine Practice Guidelines state that engineering controls, including ergonomic workstation evaluation and modification, and job redesign to accommodate a reasonable proportion of the workforce may well be the most cost effective measure in the long run. Within the documentation available for review, it is unclear exactly what ergonomic problems are present at the patient's worksite. The patient's mechanism of injury was apparently from picking up a heavy item that had fallen rather than due to an injury from poor ergonomics. The requesting physician has not identified what type of biomechanical issues are felt to be contributing to the patient's ongoing symptoms. In the absence of clarity regarding those issues, the currently requested workstation ergonomic evaluation and adjustment is not medically necessary.

Flurbiprofen 10/5-Cyclobenzaprine 1%-Gabapentin 6%-Lidocaine 2%-Prilocaine 2% in Lidoderm Activemax #1 with 5 refills, per 04/01/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for topical medication, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical lidocaine is "Recommended

for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested topical medication is not medically necessary.

Physical Therapy evaluation and treatment, 2 x per week x 6 weeks, lumbar spine, per 02/05/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Steroid injection with Lidocaine, Marcaine and Kenalog under ultrasound guidance, left shoulder, per 03/05/15 order: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Regarding the request for shoulder injection, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go

on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, there is no indication of significant activity limitation due to shoulder pain with elevation. Furthermore, ultrasound guidance is not supported by the guidelines and, unfortunately, there is no provision for modification of the request to allow for injection without ultrasound guidance. As such, the currently requested shoulder injection is not medically necessary.