

Case Number:	CM14-0121732		
Date Assigned:	08/08/2014	Date of Injury:	04/24/2013
Decision Date:	10/06/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/01/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 56-year-old female who sustained a vocational injury to her shoulder on April 24, 2013 while lifting heavy binders. The office note dated July 14, 2014, documented diagnoses of cervical strain/sprain with multilevel degenerative disc disease from C3-4 through C6-7 consisting of disc osteophyte complexes, mild to moderate left neural foraminal stenosis at C5-6; right shoulder impingement syndrome with partial tear to the supraspinatus and subscapularis tendons and mild low grade acromioclavicular joint arthrosis; lumbar sprain/strain, facet arthropathy on the left at L5-S1. The pain radiated into both shoulders and into the right hand. Physical examination of the cervical spine demonstrated tenderness to palpation of the right greater than the left of the C5-6 and C6-7 areas as well as bilateral upper trapezius, bilateral lower scapular and bilateral rhomboids. Flexion was at 45 degrees, extension to 60 degrees, right rotation to 70 degrees, and left rotation to 50 degrees. Examination of the right shoulder revealed tenderness to palpation of the pectoralis, subacromial bursa, teres major, infraspinatus, lateral deltoids, biceps tendon and triceps belly. There was pain with flexion, abduction and external rotation. Range of motion was reduced with flexion to 90 degrees, extension to 30 degrees, external and internal rotation to 45 degrees, abduction to 70 degrees and adduction to zero degrees. Neer and Hawkins' testing were positive. Jobe's sign was equivocal. Cross adduction sign and Speed's testing were negative. The report of the MRI of the cervical spine from September 15, 2013 showed mild diffuse congenital spinal canal stenosis. There was superimposed multilevel disc disease of the spinal canal and neural foraminal narrowing. No significant change at C2-3. There was a small disc osteophyte complex at C3-4 with mild spinal canal stenosis and mild bilateral neural foraminal stenosis. At C4-5, there was only disc desiccation and minimal diffuse disc bulge. At C5-6 a small diffuse disc osteophyte complex eccentric to the left and mild spinal canal stenosis, mild right and mild to moderate left neural

foraminal stenosis. At C6-7 there was small to moderate diffuse disc osteophyte complex with moderate spinal canal stenosis and mild bilateral neural foraminal stenosis. The report of the MRI of the right shoulder from October 2, 2013 showed partial low grade bursal and articular surface tears involving the supraspinatus and subscapularis tendons. The remainder of the rotator cuff and biceps tendon mechanism remained intact. There was mild acromioclavicular degenerative joint disease. Shoulder x-rays showed type I acromion configuration on the left and type II acromial configuration on the right. The documentation indicated that conservative treatment has included acupuncture, Lidoderm patch, right subacromial cortisone injection on May 14, 2014, and Biofreeze. This request is for acromioplasty and debridement as indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative physical therapy times 24 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

With acromioplasty and debridement as indicated: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: California ACOEM Guidelines recommend that prior to considering surgical intervention, there should be clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair as well as documentation of failure to increase range of motion and strengthening of the musculature around the shoulder even after exercise programs plus the existence of a surgical lesion. ACOEM also recommends that it is also generally recommended that all other pain generators, most notably and importantly in this situation cervical spine pathology and pain, be ruled out prior to considering and proceeding with surgical intervention. In the setting of a partial thickness rotator cuff tear and impingement, there should be minimum documentation of three to six months of continuous conservative treatment to include formal physical therapy, home exercise program, antiinflammatories, Tylenol, activity modifications, and injection therapy prior to considering and recommending surgical intervention. The documentation presented for review suggests the claimant has ongoing complaints in her cervical spine and appears to have pathology associated with radicular complaints which may be responsible for the ongoing shoulder pain for which surgical intervention would not provide significant relief. In addition,

the request fails to establish the laterality of the requested extremity which would be imperative to note prior to determining the medical necessity. There is a lack of documentation the claimant has attempted, failed and exhausted a continuous course of conservative treatment prior to recommending and considering surgical intervention. Therefore, based on the documentation presented for review and in accordance with California ACOEM Guidelines, the request for the acromioplasty and debridement cannot be considered medically necessary.

Surgistim transcutaneous electrical nerve stimulation (TENS) unit:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: The request for the acromioplasty and debridement cannot be considered medically necessary. Therefore, the request for the SurgiStim TENS unit cannot be considered medically necessary. In addition, documentation fails to establish the claimant has failed traditional first line conservative treatment options and subsequently transcutaneous electrotherapy would not be considered medically necessary.

Lidoderm patches 5%, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch); Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: In regards to the request for Lidoderm patches 5%, dispense #30, California Chronic Pain Medical Treatment Guidelines support the use of Lidoderm patches as a first line treatment only for postherpetic neuralgia or localized peripheral pain after there has been evidence of a trial of first line therapy. The documentation provided for review fails to support the claimant has met criteria to consider Lidoderm patches as medically necessary and reasonable and subsequently the request cannot be considered medically reasonable and necessary.

Biofreeze, #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The product website

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines note that topical analgesics are considered largely experimental in nature. They should only be considered after there has been attempted and failed exhaustive traditional first line conservative treatment which does not appear to be the situation in this case. There is no significant recent available literature supporting Biofreeze is medically necessary in the setting of chronic pain, arthritis or synovitis. Therefore, based on the documentation presented for review and in accordance with California MTUS Chronic Pain Guidelines, the request for Biofreeze #1 cannot be considered medically necessary.

Amitriptyline HCL 10 mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nortriptyline (Amitriptyline): Neuropathic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13-15.

Decision rationale: The Chronic Pain Guidelines recommend that amitriptyline is a tricyclic antidepressant and generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Currently, there are no abnormal physical exam objective findings or working diagnosis presented for review in the documentation suggesting that the claimant has depression, fibromyalgia, or pain that may be relieved with tricyclic antidepressants. The medical necessity of the medication is not well established and subsequently cannot be considered medically necessary.