

<b>Case Number:</b>	CM14-0121939		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	05/06/2014
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Family Practice and is licensed to practice in Texas. 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 injured worker is a 31-year-old female who reported an injury on 05/06/2014. The injured worker sustained injuries to her right shoulder when she was attempting to open a jammed door, when she felt a pop. The injured worker's treatment history included MRI studies, medications, and physical therapy sessions. She was evaluated on 07/22/2014 and it was documented that the injured worker complained of right shoulder pain. The provider noted she was not doing many chores around the house. She had no numbness or tingling recently. Had difficulty reaching or overhead activities. Her pain was constant. Objective findings: her blood pressure was 110/64 with a pulse of 78. Shoulder abduction was 30 degrees and flexion was 30 degrees. Grade 4 strength to resistant abduction was noted. Tenderness along the biceps tendon and rotator cuff was noted. She had a positive relocation test. Apprehension test was positive. Diagnoses included impingement syndrome with cuff strain, bicipital tendonitis and instability with a positive apprehension test, sleep, stress, and depression. Medications included naproxen 550 mg, tramadol 150 mg, Protonix 20mg, LidoPro lotion, and Terocin patches. It was documented on 06/05/2014, the injured worker's initial evaluation with physical therapy regarding her right shoulder indicated that the injured worker requires skilled physical therapy in conjunction with home exercise program to address problems and achieve goals of activity of daily living. The Request for Authorization was not submitted for this review. It was documented on 07/24/2014 the injured worker tolerated treatment/therapeutic activity with minimal complaints of pain and difficulty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Integrated Treatment/Disability Duration Shoulder (Acute & Chronic)(updated 4/25/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request is not medically necessary. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted indicated the injured worker was receiving physical therapy since 06/2014 and it was documented on 07/31/2014 she noticed improved motion but still was limited. The provider failed to indicate long-term functional goals. The request failed to include frequency, duration and location where treatment is required. Given the above, the request for physical is not medically necessary.

**Protonix Tablets Delayed Release 20 Mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs), GI symptoms & card.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Protonix GI symptoms & cardiovascular risk, Page(s): 68.

**Decision rationale:** The California MTUS guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. The guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID's. The medical documentation did not indicate the injured worker had gastrointestinal symptoms. It was unclear if the injured worker had a history of peptic ulcer, GI bleed, or perforation. It did not appear the injured worker is at risk for gastrointestinal events. Moreover the request lacked frequency of medication. Therefore, the request for Protonix tablets delayed release 20 mg is not medically necessary.

**Lidopro Lotion 4 Ounces: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Topical Salicylates, Topical Analgesic, Topical Capsaicin, Lidocaine, Page(s): 1.

**Decision rationale:** California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended...Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. California MTUS guidelines indicate that topical lidocaine (Lidoderm) 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. California MTUS guidelines recommend treatment with topical salicylates. Furthermore, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The request failed to indicate where LidoPro lotion will be applied on injured worker. As such the request for LidoPro lotion 4 ounces is not medically necessary.

**Terocin Patches QTY: 20.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Terocin Patch, Topical Salicylate , Topical Analgesic,, Lidocaine, Page(s): 105, 111, 112.

**Decision rationale:** California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The California MTUS guidelines indicate that topical lidocaine (Lidoderm) 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). ...No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. California MTUS guidelines recommend treatment with topical salicylates. Terocin patches are topical Lidocaine and Menthol. The request submitted failed to indicate where Terocin patches will be applied on injured worker. As such the request for Terocin patches QTY: 20.00 is not medically necessary.

**Hot and cold compression garment QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Worker's Compensation, 2012Cold/Heat PacksContinuous-flow cryotherapy

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

**Decision rationale:** The decision for Hot and cold compression garment QTY: 1.00 is not medically necessary. The Official Disability Guidelines (ODG) recommends 7 days postop cold therapy. In a postoperative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. There is no documentation indicating the injured worker is in a postoperative setting. ODG note that local heat may provide some temporary symptomatic relief, but is generally not recommended after acute phase of injury and has no proven long term efficacy. Therefore, the request for Hot and cold compression garment QTY: 1.00 is not medically necessary.