

Case Number:	CM15-0122734		
Date Assigned:	07/07/2015	Date of Injury:	05/22/1997
Decision Date:	08/05/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/25/2015

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, 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 61-year-old male, who sustained an industrial injury on 5/22/97. Initial complaints were of multiplicity of injuries including neck; back pain right shoulder and bilateral knee pain. The injured worker was diagnosed as having cervical and lumbar disc disease; neck and back pain; right shoulder pain and right shoulder rotator cuff tear. Treatment to date has included physical therapy; medications. Diagnostic studies included MRI cervical spine (12/3/14); MRI lumbar spine (12/2/14). Currently, the PR-2 notes dated 5/5/15 indicated the injured worker complains of neck pain into the right radial arm and shoulder. He has equal pain in his neck and back. The neck pain radiates to the radial side of the right arm. He also has pain with right shoulder range of motion and movement and has been told he has right shoulder rotator cuff tear. He has had a previous rotator cuff repair. The pain is worse with driving and overhead lifting of the arm and pulling and pushing. The low back pain radiates to his bilateral hips as well as posterior and anterior thighs. The injured worker has had previous lumbar laminectomy in 1994 as well as right shoulder rotator cuff repair. He has been told he has a right rotator cuff tear. He has also had a lumbar epidural steroid injection, which he relates was painful and did not provide him significant relief. On physical examination, the provider notes the cervical spine has paraspinal tenderness and spasm. There is 5/5 strength in the bilateral deltoid, biceps, triceps, wrist flexion and extension and interossei. He has sensation intact throughout. The right shoulder reveals a positive Hawkin's sign and positive drop arm sign on the right. He had pain with the right shoulder adduction and abduction was 0 to 120 degrees. The lumbar spine exam revealed diffuse paraspinal tenderness and spam with 5/5 strength in bilateral lower extremities throughout. His sensation was intact throughout. A MRI of the cervical

spine impression notes multilevel disc disease with degeneration worse at C5-C6 and C6-C7 with mild-to moderate central and subarticular stenosis. A MRI of the lumbar spine impression notes advanced disc degeneration at L3-L4 with near complete collapse and disc height loss with osteophyte formation anteriorly and posteriorly as well as right paracentral broad-bulging disc. The provider notes that he has evidence of cervical and lumbar disc disease, but believes some of his present symptoms originate with the right shoulder. The provider administered a right shoulder injection of Lidocaine 1%/Dexamethasone. The provider's treatment plan included physical therapy for the cervical/lumbar spine 12 sessions; Lidoderm Patches 5% #30 with 2 refills and One (1) injection of 5cc Lidocaine HCL (hydrochloride) 1% and Dexamethasone 120mg/30ml to the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the cervical/lumbar spine, 12 sessions: 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 Physical medicine Page(s): 98-99.

Decision rationale: The request is for physical therapy to the cervical and lumbar regions, 12 sessions. Active physical therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function range of motion and can alleviate pain. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process. The use of active treatments is associated with substantially better outcomes than passive treatments. The patient in this case would appear to benefit from a course of active physical therapy. However, the request is for 12 visits, which exceeds the recommended 8-10 visits over 4 weeks. Therefore, the request is deemed not medically necessary at this time.

Lidoderm patches 5%, #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics: lidocaine indication: neuropathic pain.

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

Decision rationale: According to the MTUS, Lidoderm patches are indicated for localized peripheral pain after a trial of first-line agents. Lidoderm is not a first-line agent for neuropathic pain. It is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. Therefore, this request is deemed not medically necessary or appropriate at this time.

One (1) injection of 5cc Lidocaine HCL (hydrochloride) 1% and Dexamethasone 120mg/30ml to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to ACOEM Guidelines, the criteria for corticosteroid injections of the shoulder include adhesive capsulitis, impingement syndrome or rotator cuff problems. The injections are of limited proven clinical value. The total number of injections should be limited to 3/episode, allowing for assessment between injections. They are reserved for pain not adequately controlled by conservative therapies, such as physical therapy, exercise, NSAIDs and Acetaminophen. In this case, there is no documentation that the patient has failed conservative measures or has one of the diagnoses required by the above criteria. Therefore, the request is deemed not medically necessary.