

<b>Case Number:</b>	CM15-0178057		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	04/14/2011
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 56 year old female with an industrial injury dated 04-14-2011. A review of the medical records indicates that the injured worker is undergoing treatment for arthroscopic surgery shoulder rotator cuff syndrome, cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder (IVD) disorder with myelopathy, carpal tunnel syndrome of wrist and right wrist status post carpal tunnel release. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. Medical records (05-01-2015 to 08-27-2015) indicate ongoing bilateral shoulders, cervical spine and lumbar spine complaints. The injured worker rated pain a 9 out of 10. The injured worker also reported anxiety, stress and difficulty sleeping. According to the progress note dated 08-27-2015, the injured worker reported pain in the cervical spine, bilateral shoulder, thoracic, left arm, lumbar spine, sacroiliac, sacral, left pelvic, left buttock, left leg, left knee, left calf, left ankle, and right anterior wrist pain. The injured worker rated pain a 9 out of 10 and reported it was noticeable 100% of the time. The injured worker rated pain at best 5 out of 10 and 10 out of 10 at worst. The injured worker reported numbness, tingling of the left foot, left ankle, left shin, left anterior knee, left anterior leg, left foot, left ankle, left calf, left knee, left lateral epicondylitis, left buttock and left pelvic pain and reported it was noticeable 70% of the time. The injured worker reported improvement with topical compound and patches. The injured worker's symptoms are aggravated by bending, climbing, lifting, lying, sitting, walking and standing. Objective findings (8-27-2015) revealed decreased range of motion of the cervical spine and bilateral shoulder. Cervical spine Magnetic Resonance Imaging (MRI) dated 04-05-2015 revealed C2-3 disc space revealed desiccation with

normal stature with no evidence of disc protrusion. There was mild narrowing of the left lateral recess and a patent right lateral recess also noted on MRI. Right shoulder Magnetic Resonance Imaging (MRI) dated 04-12-2015 revealed tear of the supraspinatus tendon, 4 centimeters proximal to the insertion site with fluid in the subacromial subdeltoid bursa indicating a full thickness tear. Left shoulder Magnetic Resonance Imaging (MRI) dated 4-3-2015 revealed tear of the supraspinatus tendon, near the insertion site, with fluid in the subacromial subdeltoid bursa indicating a full thickness tear. The treatment plan included orthopedic specialist, physical therapy, psychotherapy report, and medication management. The treating physician reported that the injured worker may return to work with modified work restrictions. The original utilization review determination (09-02-2015) denied the request for orthopedic spine specialist consultation, orthopedic shoulder specialist consultation, bilateral shoulders, physiotherapy (2 times per week for 3 weeks) for the cervical spine, lumbar spine and bilateral shoulders, Lidoderm patches, Gabapentin 300mg; 1 by mouth 2 times per day, quantity 60, Prilosec 20mg, 1 by mouth every morning, quantity 30 and Ergonomic workstation.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Orthopedic spine specialist consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, Surgical Considerations.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of an orthopedic consultation for this patient. The clinical records submitted do not support the fact that this patient has been documented to have recent orthopedic disease requiring consultation. The California MTUS guidelines address the issue of consultants for back and neck related pain by stating: "If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps." This patient has been documented to have c2-3 disc space desiccation on MRI. The medical records indicate that they have chronic pain syndrome related to the spine with symptoms which are non-diagnostic but persistent. Physical signs of tissue insult have been documented both on physical exam as well as on imaging. However, the reason for this consultation request is not clear. Specifically, the patient has already been authorized to have a spine specialist consultation. The results of that consultation are not provided. Without recommendations and documentation of the prior consultation visit, a new request cannot be authorized. Therefore, based on the submitted medical documentation, the request for orthopedic spine specialist consultation is not-medically necessary.

**Orthopedic shoulder specialist consultation, bilateral shoulders:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, Chapter 7, Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies, Surgical Considerations.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a orthopedic consultation for this patient. The clinical records submitted do not support the fact that this patient has been documented to have recent orthopedic disease requiring consultation. The California MTUS guidelines address the issue of consultants for back and neck related pain by stating: "If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps." This patient has been documented to have bilateral tears of the supraspinatus muscle on MRI. The medical records indicate that they have chronic pain syndrome related to the shoulder with symptoms which are non-diagnostic. Physical signs of tissue insult have been documented both on physical exam as well as on imaging. However, the reason for this consultation request is not clear. Specifically, the patient has already been authorized to have a shoulder specialist consultation. The results of that consultation are not provided. Without recommendations and documentation of the prior consultation visit, a new request cannot be authorized. Therefore, based on the submitted medical documentation, the request for orthopedic shoulder specialist consultation is not- medically necessary.

**Physiotherapy (2 times per week for 3 weeks) for the cervical spine, lumbar spine and bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Specifically, the clinical records indicate this patient has already been authorized to receive PT evaluation at the requested amount. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already authorized, including milestones of: increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. Submitted reports have not adequately demonstrated that additional therapy is indicated when the prior authorized sessions have not been reported on. Therefore, based on the submitted medical documentation, the request for physiotherapy is not medically necessary.

**Lidoderm patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a Lidoderm patch prescription. In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies "tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica" as first line treatments. The provided documentation does not show that this patient was tried and failed these recommended first line treatments. Topical Lidoderm is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Therefore, based on the submitted medical documentation, the request for Lidoderm patch prescription is not medically necessary.

**Gabapentin 300mg; 1 by mouth 2 times per day, quantity 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. MTUS Chronic Pain Guidelines note Gabapentin is an anti-epilepsy drug (AEDs -also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The Guidelines recommend Gabapentin for patients with spinal cord injury as a trial for chronic neuropathic pain that is associated with this condition. The Guidelines also recommend a trial of Gabapentin for patients with fibromyalgia and patients with lumbar spinal stenosis. Within the provided documentation it did not appear the patient had a diagnosis of diabetic painful neuropathy or post herpetic neuralgia to demonstrate the patient's need for the medication at this time. Additionally, the requesting physician did not include adequate documentation of objective functional improvements with the medication or decreased pain from use of the medication in order to demonstrate the efficacy of the medication. Therefore, based on the submitted medical documentation, the request for Neurontin is not medically necessary.

**Prilosec 20mg, 1 by mouth every morning, quantity 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors)

can be utilized if the patient is concomitantly on NSAIDS and if the patient has gastrointestinal risk factors. This patient is not on NSAIDS. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for PPI use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a proton pump inhibitor exists. This patient's medical records do not support that he has GERD refractory to medical management. Furthermore, the patient has no documentation of why chronic PPI therapy is necessary. His GERD is not documented to be refractory to H2 blocker therapy and he has no records that indicate an active h. pylori infection. Therefore, based on the submitted medical documentation, the request for Prilosec prescription is not medically necessary.

**Ergonomic workstation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, Cornerstones of Disability Prevention and Management.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Prevention.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. Therefore, based on the submitted medical documentation, the request for physiotherapy is not medically necessary.