

<b>Case Number:</b>	CM14-0003753		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	08/27/2012
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/10/2014

### 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 Physical Medicine and Rehabilitation 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 51 year old female injured on 08/27/12 when she was trapped in an elevator for approximately 45 minutes and attempted to open the elevator doors resulting in an onset of right shoulder pain with swelling and right sided neck pain. The injured has undergone medication management, fourteen sessions of physical therapy, electrodiagnostic studies (EMG/NCV) of the right upper extremity, right shoulder arthroscopy on 04/10/13, additional postoperative physical therapy, and medication management. Documentation indicates complaints of constant, burning pain in the right shoulder, neck, mid back, and intermittently in the right wrist. Pain results in difficulty sleeping, pain is reported at 10/10 without medications and 7/10 with medication use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC TREATMENT SESSIONS 2 TIMES A WEEK TIMES 4 WEEKS FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Manual Therapy & Manipulation Page(s): 59.

**Decision rationale:** As noted on page 59 of the Chronic Pain Medical Treatment Guidelines, current guidelines indicate chiropractic frequency of 1 to 2 times per week the first two weeks, as indicated by the severity of the condition. Treatment may continue at one treatment per week for the next six weeks with a maximum duration of eight weeks. At week eight, patients should be reevaluated. Care beyond eight weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at one treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. There were no objective findings provided that indicated functional improvement related to the chiropractic treatments received. Additionally, a trial period to assess the benefit of chiropractic therapy would be appropriate prior to approval of additional sessions. As such, the request for chiropractic treatment sessions 2 times a week, for 4 weeks for the right shoulder cannot be recommended as medically necessary at this time.

**LIDODERM PATCH 5%, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, 9792.20, Topical Analgesics Page(s): 111.

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an Atypical Antidepressants (AED) such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore Lidoderm Patch 5%, #30 cannot be recommended as medically necessary, as it does not meet established and accepted medical guidelines.