

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0108350 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 12/29/2013 |
| Decision Date: | 10/09/2014 | UR Denial Date: | 07/03/2014 |
| Priority: | Standard | Application Received: | 07/11/2014 |

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 Nevada. 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 records presented for review indicate that this 41 year-old female was reportedly injured on 12/29/2013. The mechanism of injury is noted as a lifting injury. The most recent progress note, dated 7/03/2014, indicates that there are ongoing complaints of neck and right shoulder pain. The physical examination demonstrated positive diffuse right shoulder pain of the trapezius and posterior shoulder. Diagnostic imaging studies Includes an MRI of the right shoulder dated 3/17/2014 which reveals mild tendinopathy of supraspinatus/infraspinatus, AC joint arthropathy, and mild bursitis. The cervical spine MRI of the same date of service reveals cervical disc desiccation and straightening of the spine which may be related to pain/spasm. Previous treatment includes Cortisone injection, cryotherapy, medications, and physical therapy. A request had been made for Acupuncture #6 for cervical and right shoulder, Tramadol/APAP 37.5/325 mg, Lidopro ointment, EMG upper extremity, and was not certified in the pre-authorization process on 7/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture X 6 for Cervical and Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CCR Specialist Topics Section Page(s): 13.

Decision rationale: MTUS guidelines support acupuncture as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation to hasten functional recovery. When noting the claimant's diagnosis, date of injury, clinical presentation, and the lack of documentation of improvement from previous sessions, there is insufficient clinical data provided to support additional acupuncture; therefore, this request is not considered medically necessary.

Retrospective Request: Tramadol/APAP 37.5/325mg - dispensed on 5/20/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 11-12.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of Tramadol. As such, the request is not considered medically necessary.

Lidopro ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 105.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: Lidopro is a topical compounded preparation containing Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines note there is little evidence to support the use of topical lidocaine or menthol for treatment of chronic neck or back. As such, this request is not considered medically necessary.

EMG (electromyography) UE (upper extremities): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines - Chronic Pain - Diagnostic Investigations: Electromyography (electronically cited)

Decision rationale: ACOEM practice guidelines support electromyography (EMG) and nerve conduction velocities (NCV) to help identify subtle focal neurologic dysfunction in patients where a CT or MRI is equivocal and there are ongoing upper extremity symptoms that have not responded to conservative treatment. The claimant underwent a MRI of the cervical spine on 3/17/2017. Given the lack of documentation of positive physical finding on exam to support EMG or NCV studies, this request is not considered medically necessary.