

Case Number:	CM14-0108794		
Date Assigned:	08/01/2014	Date of Injury:	07/03/2013
Decision Date:	09/29/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/14/2014

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 Internal Medicine, and is licensed to practice in California. 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 patient suffered a worker comp injury on 7/3/13 to his left shoulder and was seeing an orthopedist for ongoing treatment. On 6/11/14 we note that the Orthopedist noted improvement of his symptoms with chiropractic treatment but still had pain with work and other activities. The patient was noted to have tenderness on palpation of the anterior rotator cuff and mild AC joint and bicipital tenderness. Also, positive impingement was noted but no shoulder instability. Also, there was noted to be accompanying pain on palpation of the neck and pain on range of motion. But, Spurling, Adson, and Wright tests were all noted to be negative. The diagnosis was left shoulder cuff tendinitis and impingement. We note that the patient had had a prior course of physical therapy. Current treatment was home exercise and soft tissue modalities as well as pain meds. A cortisone shot was administered and the M.D. requested auth for further chiropractic treatments. However, the UR rejected the request for further chiropractic treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Care 2X week for 6 Weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chiropractic treatment section Page(s): 59. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG), cervical r on page 1041 and shoulder treatment on pages 1355 and 1356.

Decision rationale: Insert Rationale Insert Rationale the Chronic Pain section of the MTUS states that chiropractic treatment should be evaluated in the first 3 to 6 visits for effectiveness and if subjective or objective improvement was noted they could be continued. A Delphi study stated that chiropractic treatment could be tried for 6 to 12 visits for 2 to 4 weeks and assessed for improvement in the midcourse of treatment as well as the end of treatment and if improvement is documented another 4 to 12 visits over 2 to 4 weeks could be offered. The ODG states that chiropractic treatment for the cervical region should be given for 2 visits over 1 week and if improvement is noted another 6 to 8 visits over 3 to 8 weeks could be offered. In the section for sprains or strains of the shoulder a total of 9 chiropractic visits over 8 weeks was offered. In this particular patient there is a note from the M.D. stating on 6/11/14 that chiropractic treatment had been beneficial and resulted in improvement in the patient's symptoms. However, she was still symptomatic and further treatments were being requested. She already had PT, cortisone shots and medications as well as home exercise program. It is felt that the continuation of chiropractic treatment would be beneficial for the patient and the UR decision is reversed and the patient should be allowed more chiropractic treatments. Therefore, this request is medically necessary.

Terocin Patch #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) medicine section page 111.

Decision rationale: Terocin patch was not specifically identified in the literature. However, it is assumed to be a topical analgesic. The MTUS states that the use of topical anesthetics is largely experimental and that there are few randomized trials that have been done to support their use. Their primary indication is in neuropathic pain that is not controlled by either antidepressant or anticonvulsant medications. Many agents are used either as monotherapy or compounded with other substances. Specific agents used are NSAID's, opioids, Capsaicin, local anesthetics, antidepressants, cannabinoids as well as other agents. Also, the MTUS states that if one drug in a compound is not acceptable the whole compound is deemed to be unacceptable. In this particular patient we have no evidence of neuropathic pain. We have a patch being recommended that was not able to be researched in the literature search, which included MTUS, ODG, Up to date, and Pub med and that is probably a topical analgesic. We noted that there is little support for the use of these topical analgesics. Lastly, topical analgesics are utilized for neuropathic pain and there is no documentation of neuropathic pain in this patient. Therefore, this request is not medically necessary.

