

Case Number:	CM14-0063327		
Date Assigned:	08/06/2014	Date of Injury:	07/12/2012
Decision Date:	09/12/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/05/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 58 year old female injured on 07/12/12 due to an undisclosed mechanism of injury. Current diagnoses include impingement syndrome of the right shoulder, acromioclavicular arthritis, rotator cuff tendonitis, left shoulder pain, adhesive capsulitis of the right shoulder and neck pain. Prior treatment includes in excess of 24 physical therapy visits without relief and medication management. Clinical note dated 04/08/14 indicates the injured worker presented complaining of constant, aching neck pain with occasional burning down into the back and upper trapezius. The injured worker also reported right shoulder pain. The injured worker rated pain at 7-8/10 with the use of medication and 9-10/10 without. Physical examination revealed posterior lateral cervical spine myofascial restrictions from the occiput to the middle trapezius and encompasses bilateral scapular area, negative Spurling's, negative Hoffmann's, decreased range of motion, strength 5/5 in all muscle groups, sensation grossly intact, reflexes are 1+ bilaterally, no clonus or increased tone, and shoulder range of motion decreased due to pain. Medications include Evista, Centrum silver, Glucosamine-Chondroitin, Benadryl, Vitamin A, aspirin low dose, Celexa, Lovaza and Vimovo. Treatment plan includes acupuncture one time per week for 6 weeks, massage therapy one time per week for 6 weeks, home exercise program, and medication management. The initial request for 6 acupuncture sessions, Terocin lotion 4oz 120ml #1 bottle and tramadol ER 150mg #60 was initially non-certified on 04/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines: Acupuncture Guidelines Official Disability Guidelines: Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. Current guidelines recommend an initial trial period of 3 - 4 sessions over 2 weeks with evidence of objective functional improvement prior to approval of additional visits. As such, the request for 6 acupuncture sessions cannot be recommended as medically necessary at this time.

Terocin Lotion 4oz 120ml #1 bottle: Upheld

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

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

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, salicylate topicals are recommended in the treatment of chronic pain. This compound is known to contain capsaicin, lidocaine, menthol, and methyl salicylate. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. However, there is no indication in the documentation that the patient cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for Terocin Lotion 4oz 120ml #1 bottle cannot be recommended as medically necessary.

Tramadol ER 150mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Guidelines indicate tramadol ER

should be initiated at 100mg with increase after 5 day period. The documentation indicates the initial dose was to be 150mg every day exceeding the recommended dose. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of tramadol ER 150mg #60 cannot be established at this time.