

<b>Case Number:</b>	CM14-0072373		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	01/22/2011
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 54-year-old individual was reportedly injured on January 22, 2011. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated May 7, 2014, indicated that there were ongoing complaints of left shoulder pain, tenderness of the cervical spine and decreased sensation. The physical examination demonstrated tenderness to palpation in the cervical spine and left upper extremity and decreased sensation in C6 and C7. Diagnostic imaging studies were not reported. Previous treatment included multiple medications and pain management interventions. A course of physical therapy was also outlined. A request had been made for multiple medications, acupuncture and physical therapy and was not certified in the pre-authorization process on May 15, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/OPIOIDS Page(s): 82-8.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91.

**Decision rationale:** As noted in the MTUS, this medication is a short acting opioid indicated for the management of moderate to severe breakthrough pain. The progress notes presented for you do not indicate that there has been any significant efficacy with the utilization of this medication. The pain complaints are elevated, there are no noted increases in functionality, and are no return to work. Therefore, when combining the clinical information presented for review with the parameters noted in the ODG, there is no clinical indication for the continued use of this medication. The requested medical treatment is considered not medically necessary.

**Terocin Patches #10: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/TOPICAL ANALGESICS Page(s): 105,111-113. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 105, 112.

**Decision rationale:** Terocin is a topical analgesic containing lidocaine and menthol. MTUS guidelines support topical lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for menthol. 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". When noting there has not been any significant objectified improvement with the utilization of this topical preparation, this request is considered not medically necessary.

**10 sessions of Acupuncture left shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 13.

**Decision rationale:** As noted in the MTUS, acupuncture can be used if there is a corresponding decreasing medication or increased function. Seeing none, there is insufficient clinical evidence presented to suggest this has any efficacy or utility. Therefore, based on the clinical information presented for review, this is not medically necessary.

**Physio Therapy Left Shoulder X6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83, Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/PHYSICAL THERAPY Page(s): 103.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209.

**Decision rationale:** When noting the date of injury, the injury sustained, and the current diagnosis offered, there is insufficient clinical information presented as to why additional physical therapy is warranted. As outlined in the ACOEM guidelines, transition to home exercise protocol is all that would be supported. Therefore, based on the clinical rationale presented, the requested treatment is not medically necessary.