

Case Number:	CM15-0017633		
Date Assigned:	02/05/2015	Date of Injury:	11/05/2014
Decision Date:	05/19/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	01/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 42-year-old male, who sustained an industrial injury on November 5, 2014. The mechanism of injury was lifting a heavy desk. He has reported right shoulder and clavicle pain. The diagnoses have included shoulder/clavicle pain and myofascial strain. Treatment to date has included radiographic imaging, diagnostic studies, pain medications, work modifications, injections and conservative therapies. The injured worker reported right shoulder and clavicle pain after an industrial injury in 2014. X-rays of the shoulder and clavicle were unremarkable on November 7, 2014 revealing only a small inferior bone spur at the distal end of the clavicle. The documentation of 01/07/2015 revealed subjective complaints of neck pain, clavicle pain and right shoulder and arm pain. The objective findings revealed cervical spine tenderness to palpation and spasms bilaterally in the paraspinal muscles, occipital muscles, suboccipital muscles, bilateral trapezius muscles, and levator scapula. There was decreased range of motion and a positive compression test. There was a right shoulder deformity at the sternoclavicular joint and tenderness to palpation anteriorly and posteriorly, and laterally in the clavicle, biceps muscle, biceps tendon groove, deltoid muscle and AC joint. There was decreased range of motion and a positive Neer and Codman's test. No x-rays were performed. The diagnoses included cervical musculoligamentous sprain and strain with radiculitis, rule out cervical spine discogenic disease, right shoulder tendinitis, status post right clavicle dislocation with residual deformity. The treatment plan included Somnicin, Terocin patches, hot and cold unit, urine toxicology for medication monitoring, an MRI of the cervical spine, CT of the right shoulder at the sternoclavicular joint and EMG/NCV of the bilateral upper extremities as well as

physical therapy evaluation and treatment for the cervical spine and right shoulder 2 times a week for 6 weeks. On January 22, 2015, Utilization Review non-certified a request for Somnicin, Terocin patches #60, noting the MTUS, ACOEM Guidelines, (or ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Somnicin: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://sales.advancedrxmgt.com/sales-content/uploads/2012/04/Somnicin-Patient-Info-Sheet.pdf>.

Decision rationale: The Official Disability Guidelines indicates that non-pharmacologic treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention and is a first line treatment for insomnia. Per advancedrxmgt.com, the ingredients include Melatonin, 5-HTP, L-tryptophan, compound B-6 and Magnesium. Additionally, the Official Disability Guidelines, melatonin is recommended in the treatment of sleep disorders. A thorough search of the California Medical Treatment Utilization Schedule, Official Disability Guidelines, and the National Guideline Clearinghouse failed to reveal guidelines or scientific evidence to L-tryptophan, pyridoxine, or magnesium in the management of insomnia. The clinical documentation submitted for review failed to provide documentation the injured worker had difficulty sleeping. The request as submitted failed to indicate the frequency for the requested medication as well as the quantity. Given the above, the request for 1 prescription of Somnicin is not medically necessary.

1 prescription of Terocin patches #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Lidocaine Page(s): 105, 111, 112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety "are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate

that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical Lidocaine and Menthol. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the body part and frequency for the requested medication. Given the above, the request for 1 prescription of Terocin patches #60 is not medically necessary.

1 Hot and Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: The ACOEM Guidelines indicate that at home local applications of cold packs during the first few days of an acute complaint are appropriate, thereafter, applications of heat packs. There was a lack of documentation indicating a necessity for a hot and cold unit and that the injured worker could not utilize at home local applications of heat and cold packs. The request as submitted failed to indicate the frequency, duration and whether the unit was for rental or purchase. The request as submitted failed to indicate the body part to be treated. Given the above, the request for 1 hot and cold unit is not medically necessary.

Urine drug test: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California MTUS indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review indicated the request was made for the urine drug screen for medication monitoring. However, the medications that were prescribed were not noted. There was a lack of documentation indicating the injured worker had documented issues of abuse, addiction or poor pain control. Given the above, the request for urine drug test is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The ACOEM Guidelines indicate that for most patients with true neck or upper back problems, special studies are not needed unless there has been a 3 or 4 week period of conservative care and observation that fails to improve symptoms. The criteria for ordering imaging studies includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The clinical documentation submitted for review failed to provide documentation of physiologic evidence, and a documented failure of conservative care specifically for the cervical spine. Given the above, the request for MRI of the cervical spine is not medically necessary.

1 CT scan of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The ACOEM guidelines indicate that for most patients with shoulder problems, special studies are not needed unless there has been a 4 to 6 week period of conservative care and observation. The primary criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedures. The clinical documentation submitted for review failed to provide the rationale for the CT of the right shoulder. Documentation indicated that the injured worker underwent an x-ray of the right shoulder and clavicle on 11/07/2014, which was unremarkable with only a small inferior bone spur at the distal end of the clavicle. There was a lack of documentation indicating conservative care that had been utilized for the shoulder specifically. Given the above and the lack of documented rationale, the request for CT scan of the right shoulder is not medically necessary.

NCV/EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The American College of Occupational and Environmental Medicine states that Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There should be documentation of 3 - 4 weeks of conservative care and observation. The clinical documentation submitted for review failed to indicate the injured worker had subtle focal neurologic dysfunction and that the neck or arm symptoms had lasted more than 3 or 4 weeks. There was a lack of documentation of specific conservative care for the upper extremities. The request was con-currently submitted with a request for physical therapy for the cervical spine. Given the above, the request for an NCV/EMG of the bilateral upper extremities is not medically necessary.

12 physical therapy sessions for the cervical spine and right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The California MTUS Guidelines indicate that 10 sessions of physical medicine treatment are appropriate for the treatment of myalgia and myositis. The clinical documentation submitted for review failed to provide documentation of the prior conservative care that was participated in. There was a lack of documentation of exceptional factors to support exceeding guideline recommendation of a maximum of 10 sessions. Given the above, the request for 12 physical therapy sessions for the cervical spine and right shoulder is not medically necessary.