MAXIMUS Federal Services

Case Number:	CM15-0134547		
Date Assigned:	07/22/2015	Date of Injury:	01/31/2013
Decision Date:	10/06/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/13/2015

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: Pennsylvania
Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 41 year old male sustained an industrial injury on 1/31/13. He subsequently reported neck and back pain. Diagnoses include neck pain and sprain, bilateral carpal tunnel syndrome and strain of upper extremity. Treatments to date include MRI testing, injections, acupuncture, chiropractic care, physical therapy, and prescription pain medications. The injured worker continues to experience neck pain radiating to the bilateral upper extremities, bilateral shoulder pain radiating to the hands and fingers, bilateral wrist pain and spasm, mid back pain and GI symptoms. Upon examination, there was tenderness and decreased ranges of motion noted in the bilateral shoulders, bilateral wrists, thoracic and cervical spine. Cervical distraction, foraminal compression test, Tinel's and Phalen's bilaterally were positive. A request for Additional physical therapy (cervical and right shoulder) QTY: 18, Additional acupuncture (cervical and right shoulder) QTY: 18, Additional chiropractic therapy (cervical and right shoulder) QTY: 18, Shockwave treatments to the right shoulder QTY: 3, Shockwave treatments to the cervical QTY: 6, Terocin patches QTY: 1 and Platelet-rich plasma (PRP) treatment to the right shoulder QTY: 1 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy (cervical and right shoulder) QTY: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The MTUS Guidelines support the use of physical therapy, especially active treatments, based on the philosophy of improving strength, endurance, function, and pain intensity. This type of treatment may include supervision by a therapist or medical provider. The worker is then expected to continue active therapies at home as a part of this treatment process in order to maintain the improvement level. Decreased treatment frequency over time (fading) should be a part of the care plan for this therapy. The Guidelines support specific frequencies of treatment and numbers of sessions depending on the cause of the workers symptoms. The submitted records indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. There was no discussion describing a sufficient reason therapist-directed physical therapy would be expected to provide more benefit than a home exercise program at or near the time of the request. In the absence of such evidence, the current request for 18 additional physical therapy sessions for the right shoulder and neck/upper back region is not medically necessary.

Additional acupuncture (cervical and right shoulder) QTY: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The MTUS Guidelines support the use of physical therapy, especially active treatments, based on the philosophy of improving strength, endurance, function, and pain intensity. This type of treatment may include supervision by a therapist or medical provider. The worker is then expected to continue active therapies at home as a part of this treatment process in order to maintain the improvement level. Decreased treatment frequency over time (fading) should be a part of the care plan for this therapy. The Guidelines support specific frequencies of treatment and numbers of sessions depending on the cause of the workers symptoms. The submitted records indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. There was no discussion describing a sufficient reason therapist-directed physical therapy would be expected to provide more benefit than a home exercise program at or near the time of the request. In the absence of such evidence, the current request for 18 additional physical therapy sessions for the right shoulder and neck/upper back region is not medically necessary.

Additional chiropractic therapy (cervical and right shoulder) QTY: 18: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The MTUS Guidelines recommend chiropractic care for chronic pain that is due to musculoskeletal conditions. However, this treatment is not recommended for treatment of the ankle and foot, carpal tunnel syndrome, the forearm, the wrist and hand, or the knee. When this treatment is recommended, the goal is improved symptoms and function that allow the worker to progress in a therapeutic exercise program and return to productive activities. An initial trial of six visits over two weeks is supported. If objective improved function is achieved, up to eighteen visits over up to eight weeks is supported. The recommended frequency is one or two weekly sessions for the first two weeks then weekly for up to another six weeks. If the worker is able to return to work, one or two maintenance sessions every four to six months may be helpful; the worker should be re-evaluated every eight weeks. The documentation must demonstrate improved function, symptoms, and quality of life from this treatment. Additional sessions beyond what is generally required may be supported in cases of repeat injury, symptom exacerbation, or comorbidities. The worker should then be re-evaluated monthly and documentation must continue to describe functional improvement. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. There was no discussion detailing functional issues, the goals of this therapy, why additional treatment was likely to be of benefit, or suggesting why more sessions than are generally supported by the Guidelines were needed. In the absence of such evidence, the current request for 18 additional chiropractic sessions for the right shoulder and neck/upper back region is not medically necessary.

Shockwave treatments to the right shoulder QTY: 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Activity Modification, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References, and Elbow Complaints 2007, Section(s): Impact, Recommendations, Basic Principles, Anatomy, Diagnostic Criteria, Contusion, Olecranon Bursitis (Aseptic), Radial Head Fracture, Dislocation of Elbow, Sprain of Elbow, Biceps Tendinitis, Ulnar Nerve Entrapment, Radial Nerve Entrapment, Pronator Syndrome, Lateral Epicondylalgia, Medial Epicondylalgia, Chronic Pain Considerations, Summary, References, and Ankle and Foot Complaints 2004, Section(s): General Approach,

Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Activity Alteration, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References. Decision based on Non-MTUS Citation Khan K, et al. Overview of the management of overuse (chronic) tendinopathy. Topic 13803, version 6.0. UpToDate, accessed 09/20/2015.Fields KB, et al. Hamstring muscle and tendon injuries. Topic 13810, version 28.0. UpToDate, accessed 09/20/2015.

Decision rationale: The ACOEM Guidelines support the use of shock wave therapy for some cases of calcifying shoulder tendinitis and plantar fasciitis, although the literature is limited. There is no good literature to support the use of shock wave therapy for back, elbow, knee, thigh, or wrist issues. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. The submitted and reviewed documentation did not include a discussion of special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for three shockwave therapy treatments for the right shoulder is not medically necessary.

Shockwave treatments to the cervical QTY: 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Activity Modification, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References, and Elbow Complaints 2007, Section(s): Recommendations, Basic Principles, Anatomy, Impact, Diagnostic Criteria, Contusion, Olecranon Bursitis (Aseptic), Radial Head Fracture, Dislocation of Elbow, Sprain of Elbow, Biceps Tendinitis, Ulnar Nerve Entrapment, Radial Nerve Entrapment, Pronator Syndrome, Lateral Epicondylalgia, Medial Epicondylalgia, Chronic Pain Considerations, Summary, References, and Ankle and Foot Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Activity Alteration, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References. Decision based on Non-MTUS Citation Khan K, et al. Overview of the management of overuse (chronic) tendinopathy. Topic 13803, version 6.0. UpToDate, accessed 09/20/2015. Fields KB, et al. Hamstring muscle and tendon injuries. Topic 13810, version 28.0. UpToDate, accessed 09/20/2015.

Decision rationale: The ACOEM Guidelines support the use of shock wave therapy for some cases of calcifying shoulder tendinitis and plantar fasciitis, although the literature is limited. There is no good literature to support the use of shock wave therapy for back, elbow, knee, thigh, or wrist issues. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders

that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. The submitted and reviewed documentation did not include a discussion of special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for six shockwave therapy treatments for the neck and upper back is not medically necessary.

Platelet-rich plasma (PRP) treatment to the right shoulder QTY: 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Khan K, et al. Overview of the management of overuse (chronic) tendinopathy. Topic230, version 18.0. UpToDate. Accessed 10/04/2015. Moraes VY, et al. Platelet-rich therapies for musculoskeletal soft tissue injuries. Cochrane Database Syst Rev 2013; 12: CD010071.

Decision rationale: The MTUS Guidelines are silent as to the issue of the use of injected platelet-rich plasma (PRP) in this setting. Studies of this therapy are limited. A Cochrane Database systematic review evaluated nineteen studies and concluded that the available data was insufficient to support the use of this therapy. While smaller studies have suggested some potential benefit in healing, others have suggested decreased healing. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. The records included detailed symptoms and objective findings consistent with these issues. However, there was no discussion reporting extenuating circumstances to support the use of PRP in this setting. In the absence of such evidence, the current request for injected platelet-rich plasma (PRP) to the right shoulder is not medically necessary.

Terocine patches QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS Guidelines strongly emphasize that any compound product that contains at least one drug or drug class that is not recommended is itself not recommended. The requested compound contains the medications 4% Lidocaine (an anesthetic) and 4% menthol (a pain reliever). The MTUS Guidelines recommend topical Lidocaine for localized pain after first-line treatment has failed to manage it sufficiently. Only the dermal patch is FDA-approved and

recommended by the Guidelines. Topical menthol is not recommended by the MTUS Guidelines. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck and upper back that goes into the shoulder, pain in both shoulders that goes into the fingers, pain in both wrists with spasms, mid- and lower back pain with lower back spasm, anxious and depressed moods, problems sleeping, and numbness and tingling in the legs. There was no discussion reporting special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for one Terocin (topical 4% Lidocaine with 4% menthol) patch is not medically necessary.