

Case Number:	CM15-0184501		
Date Assigned:	10/01/2015	Date of Injury:	04/24/2014
Decision Date:	12/09/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/18/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 33 year old male, who sustained an industrial injury on 4-24-2014. The medical records indicate that the injured worker is undergoing treatment for cervical spine herniated nucleus pulposus, cervicgia, cervical radiculopathy, bilateral shoulder pain, right shoulder tendonitis, right elbow pain, rule out right elbow internal derangement, lumbar spine herniated nucleus pulposus, lumbago, and lumbar radiculopathy. According to the progress report dated 7-30-2015, the injured worker presented with complaints of burning, radicular neck pain and spasms, burning, shoulder pain with radiation down the arms to the level of his fingers, associated with spasms, burning right elbow pain with spasms, and burning, radicular low back pain, associated with numbness and tingling in the bilateral lower extremities. On a subjective pain scale, he rates his pain 6-7 out of 10. The physical examination of the cervical spine reveals tenderness to palpation over the paraspinal muscles and restricted range of motion. Examination of the right shoulder reveals generalized tenderness and limited range of motion. Examination of the right elbow reveals tenderness over the left medial and lateral epicondyle and reduced range of motion. Examination of the lumbar spine reveals tenderness to palpation over the paraspinal muscles and reduced range of motion. Previous diagnostic testing includes MRI studies. Treatments to date include medication management. Work status is described as off work. The original utilization review (8-28-2015) had non-certified a request for HMPC2 (Flurbiprofen 20%, Baclofen 10%, Dexamethasone Micro 0.2%, Hyaluronic Acid 0.2%), HNPC1(Amitriptyline HCL 10%, Gabapentin 10%, Bupivacaine HCL 5%, Hyaluronic Acid 0.2%), Ketoprofen cream, Cyclobenzaprine cream, Synapryn, Tabradol, Deprizine,

Dicoprofol, Fanatrex, urine drug screen, MRI of the cervical and lumbar spine, MRI of the right shoulder, pain management consultation, 18 sessions of physical therapy, chiropractic, and acupuncture to the cervical spine, lumbar spine, and bilateral shoulders, 3 shockwave therapy sessions to the right elbow, 6 neurostimulator therapy to the lumbar spine, and 3 sets of platelet rich plasma treatments to the cervical spine, lumbar spine, bilateral shoulders, and right elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

HMPC2-Flurbiprofen 20%/Baclofen 10%/Dexamethasone Micro 0.2%/Hyaluronic Acid 0.2% in cream base 240gm: 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): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines address the topic of compound medication prescriptions. In accordance with California MTUS guidelines, topical analgesics are considered "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines go on to state that, "There is little to no research to support the use of many of these agents." The guideline specifically says, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Compounded medications are not subject to FDA oversight for purity or efficacy. Therefore, based on the submitted medical documentation, the request for HMPC2-Flurbiprofen 20%/Baclofen 10%/Dexamethasone Micro 0.2%/Hyaluronic Acid 0.2 ointment prescription is not medically necessary.

HNPC1-Amirtipyline HCL 10%/Gabapentin 10%/Bupivacaine HCL 5%/Hyaluronic Acid 0.2% in cream base 240gm: 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): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines address the topic of compound medication prescriptions. In accordance with California MTUS guidelines, topical analgesics are considered "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines go on to state that, "There is little to no research to support the use of many of these agents." The guideline specifically says, "Any compounded product that contains at least one drug (or drug class) that is not recommended is

not recommended." Compounded medications are not subject to FDA oversight for purity or efficacy. Therefore, based on the submitted medical documentation, the request for HNPC1-Amirtipityline HCL 10%/Gabapentin 10%/Bupivacaine HCL 5%/Hyaluronic Acid 0.2% ointment prescription is not medically necessary.

Ketoprofen cream 20% cream 167gm: 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): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of treatment of Ketoprofen cream for this patient. The California MTUS guidelines address the topic of NSAID prescriptions by stating, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics." Furthermore, MTUS guidelines specifically state regarding topical Non-steroidal ant inflammatory agents (NSAIDs): "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Compounded medications are not subject to FDA oversight for purity or efficacy. The medical records do not support that the patient has osteoarthertitis or a contraindication to other non-opioid analgesics. Therefore, medical necessity for Ketoprofen cream prescription has not been established.

Cyclobenzaprine 5% cream 110gm: 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): Muscle relaxants (for pain).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." This patient has been diagnosed with chronic hand pain, arm pain and back pain. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine cream is not medically necessary.

Synapryn 10mg/1ml oral suspension 500ml: 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): Glucosamine (and Chondroitin Sulfate).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Synapryn, per the National Library of Medicine (NLM), is an amalgam of tramadol and glucosamine. While page 50 of the MTUS Chronic Pain Medical Treatment Guidelines notes that glucosamine is indicated in the treatment of arthritis and, in particular that associated with knee arthritis. In this case, however, there was no mention of the applicant's having any issues with either arthritis and/or knee arthritis for which usage of glucosamine would have been indicated. Since the glucosamine ingredient in the Synapryn amalgam is not recommended, the entire amalgam is not recommended. Therefore, based on the submitted medical documentation, the request for MRI of the ankle is not medically necessary.

Tabradol 1mg/ml oral suspension 250ml: 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): Cyclobenzaprine (Flexeril).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Tabradol, per the National Library of Medicine (NLM), is an amalgam of cyclobenzaprine and MSM. However, page 113 of the MTUS Chronic Pain Medical Treatment Guidelines notes that cyclobenzaprine is not recommended for topical compound formulation purposes. Since one or more ingredients in the amalgam is not recommended, the entire amalgam is not recommended, per page 113 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, based on the submitted medical documentation, the request for tabradol is not medically necessary.

Deprizine 15mg/ml oral suspension 250ml: 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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While the MTUS Chronic Pain Medical Treatment Guidelines notes that H2 antagonists such as ranitidine (Deprizine) are indicated in the treatment of NSAID-induced dyspepsia. In this case, however, there was no mention of the applicant's having any issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone, on or around the date in question. Therefore, based on the submitted medical documentation, the request for Deprizine is not medically necessary.

Dicopanol 5mg/ml oral suspension 150ml: 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): Nonprescription medications.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While the MTUS does not specifically address the topic of Dicopanol (diphenhydramine), the MTUS Guideline in ACOEM Chapter 3, page 47 does stipulate that it is incumbent upon a prescribing provider to discuss the efficacy of the medication for the particular condition for which it is being prescribed. Here, the attending provider did not clearly state or stipulate for which condition or conditions Dicopanol (diphenhydramine) was being prescribed. While the National Library of Medicine (NLM) acknowledges that Dicopanol is indicated in the treatment of allergic reactions, motion sickness, and/or Parkinsonism, in this case, however, there was no mention of the applicant's having any issues with Parkinsonism, motion sickness, etc., on or around the date in question. Therefore, based on the submitted medical documentation, the request for Dicopanol is not medically necessary.

Fanatrex 25mg/ml oral suspension 420ml: 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): Antiepilepsy drugs (AEDs).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While page 49 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that gabapentin is indicated in the treatment of localized peripheral pain or neuropathic pain as was/is present here in the form of the applicant's digital paresthesia's, this recommendation is, however, qualified by commentary made on page 47 of the ACOEM Practice Guidelines and on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of "cost" into his choice of pharmacotherapy. Here, the attending provider did not clearly outline why a custom compounded, brand-name Fanatrex agent was being employed in favor of generic gabapentin. The attending provider, thus, did not incorporate any discussion of cost into his choice of pharmacotherapy. Therefore, based on the submitted medical documentation, the request for Fanatrex is not medically necessary.

1 Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine drug testing (UDT).

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and past drug screens are consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request for drug screening is not medically necessary.

1 MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The California MTUS guidelines state regarding special studies of the Cervical spine, "Criteria for ordering imaging studies are: 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." Regarding this patient's case, this patient had an MRI performed 1 year ago in June 2014. The documentation provided does not suggest any significant change in symptoms. No new red flags are documented. No evidence of change in neurological dysfunction or tissue insult from the time of the patient's prior scan. Likewise, there is no documentation of a planned eminently invasive procedure. Therefore, based on the submitted medical documentation, the request for an MRI of the cervical spine is not medically necessary.

1 MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACEOM Low Back Complaints, referenced by CA MTUS guidelines. 303-305.

Decision rationale: The MTUS guidelines recommend that: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery." In this patient's case, the patient's physical exam does not document any red flag symptoms (bowel/bladder incontinence, saddle anesthesia, fevers) or new neurologic deficits to warrant a lower back MRI study. The patient's complaints of pain are subjective, chronic and not in a new radicular distribution. Therefore, based on the submitted medical documentation, the request for a MRI of the lumbar spine is not medically necessary.

1 MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations, Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a shoulder MRI for this patient. The MTUS guidelines recommend the following criteria for ordering special imaging studies in shoulder complaints: Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Reynaud's phenomenon); Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure (e.g., a full- thickness rotator cuff tear not responding to conservative treatment) Regarding this patient's case, the patient does not have any red flag signs, including neurovascular impairment, torticollis or concerning local features such as a mass lesion with bony tenderness or swelling. Therefore, based on the submitted medical documentation, the request for a MRI of the left shoulder is not medically necessary.

1 Pain management consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of pain management referral for this patient. Per MTUS, "Patients not responding to initial or subacute management or those thought to be at risk for delayed recovery should be identified as early as possible." This patient has been demonstrated to have failed multiple type of medication for pain control. Use of other modalities including acupuncture, chiropractor, medication and physical therapy have not been documented. Referral for pain management evaluation has the potential to allow for functional improvement with adequate pain control if multiple treatment modalities fail. Since this patient has only used medication to date, referral is not indicated. Therefore, based on the submitted medical documentation, the request for pain management evaluation is not medically necessary.

18 Sessions of physical therapy for the cervical spine, lumbar spine and bilateral shoulders:
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: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support formal PT for longer than 9-10 sessions. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. Therefore, based on the submitted medical documentation, the request for 18 sessions of physical therapy is not medically necessary.

18 Sessions acupuncture for the cervical spine, lumbar spine and bilateral shoulders:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of acupuncture testing for this patient. The California MTUS Acupuncture guidelines address the topic of neck/cervical acupuncture. In accordance with California MTUS Acupuncture guidelines "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented." This patient has been prescribed acupuncture for 18 sessions. This exceeds MTUS recommendations for trial. Therefore, based on the submitted medical documentation, the request for acupuncture testing is not medically necessary.

18 Sessions chiropractic manipulation for the cervical spine, lumbar spine and bilateral shoulders: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient.

The California MTUS Guidelines state that Chiropractic manipulation is recommended for the treatment of chronic pain that has acute flares or "requires therapeutic care." However, it is "not recommended for elective for maintenance therapy." The medical records support that this patient has chronic back pain which has been stable with no recent acute interventions. The patient's pain appears to be at a steady state for which he has been receiving multiple medications. MTUS does not support the need for manipulation as maintenance therapy. Therefore, based on the submitted medical documentation, medical necessity for chiropractic therapy has not been established.

3 Sessions of shockwave therapy for the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

MAXIMUS guideline: The Expert Reviewer did not base their decision on MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Back Pain, Shockwave Therapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient.

The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be

monitored closely." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the provided documentation, the Guidelines recommend the use of shockwave treatment for the shoulder; however, there are no indications for use in the back. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Additionally, the requesting physician's rationale for the request was unclear. The request is not medically necessary.

6 Sessions of localized intense neurostimulation therapy for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic, Hyperstimulation analgesia.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient.

The California MTUS guidelines, Occupational Disability Guidelines and the ACOEM Guidelines do not address this topic. Therefore, alternative sources were sought. Based on the description of the modality in question, localized intense neurostimulation therapy appears to represent a form of percutaneous electrical neurostimulation (PENS) therapy. As noted on page 97 of the MTUS Chronic Pain Medical Treatment Guidelines, PENS are not recommended as a primary treatment modality but can be considered on a trial basis if used as an adjunct to a program of evidence based functional restoration, after other nonsurgical options such as therapeutic exercise and TENS have been tried and/or failed. In this case, however, there is no clear evidence that the employee has tried and failed conventional TENS unit. There is no evidence that the employee is intent on functional restoration. Finally, there is no evidence that the employee is intent on using the proposed LINT therapy as an adjunct to functional restoration and exercise. Therefore, based on the submitted medical documentation, the request for intense neurostimulation therapy is not medically necessary.

3 Sets of platelet rich plasma (PRP) treatments for the cervical spine, lumbar spine, bilateral shoulders and right elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Low Back-Thumbar and Thoracic, Shoulder, Elbow, Platelet rich plasma (PRP).

MAXIMUS guideline: The Expert Reviewer did not base their decision on MTUS. Decision based on Non-MTUS Official Disability Guidelines (ODG), Back Pain, Acute and Chronic, Platelet Rich Plasma.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient.

Pursuant to the Official Disability Guidelines, platelet rich plasma (PRP) injection to the bilateral shoulders is not medically necessary. PRP is under study as a solo treatment. The guidelines recommend PRP augmentation as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. PRP does not help patients recover from arthroscopic rotator cuff surgery in the study. Use of plasma for chronic pain of the back is not supported by ODG or the medical literature. There is no clinical indication or clinical rationale in the medical record for platelet rich plasma injections to the shoulders bilaterally, back or spine. The therapy is not recommended or indicated. Therefore, based on the submitted medical documentation, the request for platelet rich plasma injections is not medically necessary.