

<b>Case Number:</b>	CM15-0193561		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	02/25/2014
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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, Pain Management

### 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 47 year old male who sustained an industrial injury on 2-25-2014. A review of medical records indicates the injured worker is being treated for headaches, cervical spine HNP, rule out cervical radiculopathy, bilateral shoulder internal derangement, bilateral wrist and hand pain, rule out bilateral wrist carpal tunnel syndrome, and rule out bilateral hand tenosynovitis. Medical records dated 6-17-2015 noted neck pain a 6-7 out of 10. Right shoulder pain an 8 out of 10, left shoulder pain a 5-6 out 10, right wrist pain an 8 out 10, and left wrist pain a 6 out 10. Bilateral hand pain was rated a 6 out 10. Pain was slightly better when compared to prior visit. Physical examination noted pain to the cervical spine with decreased range of motion. There was tenderness to bilateral shoulders with decreased range of motion. There was tenderness over the wrists with decreased range of motion. There was tenderness to palpation at the extensor muscle compartment. Treatment has included at least 6 visits of acupuncture and 8 visits of physical therapy. An extracorporeal shock wave therapy note dated March 11, 2015 indicates that the patient has undergone acupuncture and physical therapy but continues to have significant residual symptoms. The note indicates that the diagnosis intended to be treated with the shockwave therapy sessions include shoulder sprain/strain. The pain management consultation is requested for consideration of an epidural steroid injection in the cervical spine. Utilization review form dated 9-10-2015 noncertified terocin patches, physical therapy, acupuncture, orthopedic consultation, pain management consultation, ESI, shockwave therapy, and plasma rich therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin patches:** 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:** Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that 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 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.

**Physical therapy:** 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): Physical Medicine.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy

may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Additionally, it is unclear how many therapy sessions the patient has already undergone, and there is no statement indicating which body part is intended to be addressed with the current request for therapy. Furthermore, the current request for therapy is open-ended, and there is no provision to modify the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

**Acupuncture:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

**Decision rationale:** Regarding the request for additional acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears the patient has undergone acupuncture previously. It is unclear how many sessions have previously been provided. Additionally, there is no documentation of objective functional improvement from the therapy already provided. Furthermore, the current request for acupuncture does not include a frequency or duration of treatment. Guidelines do not support the open-ended application of any treatment modality and there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

**Orthopedic evaluation:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

**Decision rationale:** Regarding the request for consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when

psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, it appears that the requesting physician feels that further conservative treatment may be warranted at the current time (despite a lack of documentation supporting the particular conservative treatments requested). Therefore, it is unclear that a surgical indication exists. In the absence of clarity regarding those issues, the currently requested consultation is not medically necessary.

**Pain management evaluation:** 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): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Epidural Steroid Injection.

**Decision rationale:** Regarding the request for Pain management evaluation, notes indicate that evaluation is for consideration of cervical epidural steroid injection, California MTUS cites that ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), and radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. ODG states that cervical epidural steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. They go on to state that if there is a documented exception to guidelines, they may be performed, provided they are not done at higher than C6-7 level, cervical interlaminar injections are not recommended, and particulate steroids should not be used. Diagnostic epidurals may be performed when diagnostic imaging is ambiguous. Within the documentation available for review, the requesting physician has not identified why the patient would be an exception to guideline recommendations against Cervical ESI. If there is a reason why the patient would be an exception, there remains no recent subjective complaints or physical examination findings supporting a diagnosis of radiculopathy in a specific discrete dermatomal distribution, and no MRI or electrodiagnostic studies supporting a diagnosis of radiculopathy. Additionally, there is no documentation that the procedure will be performed without particulate steroid, and using a non-interlaminar approach. In the absence of such documentation, the currently requested Pain management evaluation is not medically necessary.

**Shockwave therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shockwave Therapy (ESWT).

**Decision rationale:** Regarding the request for extracorporeal shockwave therapy, Occupational Medicine Practice Guidelines support the use of extracorporeal shock wave therapy for calcified tendinitis of the shoulder. ODG further clarifies that extracorporeal shockwave therapy is recommended for calcified tendinitis of the shoulder but not for other shouldered disorders. Within the documentation available for review, there is no identification of a diagnosis of calcified tendinitis. As such, the currently requested extracorporeal shock wave therapy is not medically necessary.

**PRP (Plasma Rick P) therapy-shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Platelet Rich Plasma.

**Decision rationale:** Regarding the request for platelet rich plasma injection for the shoulder, CA MTUS does not contain criteria for this procedure. ODG states the platelet rich plasma is under study as a solo treatment, but recommended for augmentation as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. Within the documentation available for review, there is no indication that the patient has been approved for arthroscopic repair of a large or massive rotator cuff tear. In the absence of such documentation, the currently requested platelet rich plasma injection for the shoulder is not medically necessary.