

Case Number:	CM15-0201680		
Date Assigned:	10/16/2015	Date of Injury:	05/11/2014
Decision Date:	12/24/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/13/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, 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 40 year old male, who sustained an industrial-work injury on 5-11-14. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder sprain, right shoulder bursitis, rule out right elbow internal derangement and right wrist and hand derangement. Treatment to date has included pain medication, Gabapentin was tried, Terocin patch since at least 2-23-15, activity modifications and chiropractic at least 18 sessions, physical therapy at least 9 sessions and acupuncture. The current medications include Deprazine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, and Ketoprofen cream. Magnetic resonance imaging (MRI) of the right shoulder dated 5-16-15 reveals acromioclavicular joint (AC) osteoarthritis, tendinosis, posterior labrum tear and partial thickness tear. Medical records dated (3-23-15, 4-29-15, 7-30-15 and 8-31-15) indicate that the injured worker complains of burning right shoulder pain that radiates down the arms to the fingers and associated with muscle spasms. The pain is described as moderate to severe and rate 5-6 out of 10 on the pain scale which is unchanged. The pain is aggravated by increased activities and relieved by activity restriction s and medications. He states that symptoms persist but medications offer temporary relief and he denies problems with medications. Per the treating physician report dated 8-31-15 the injured worker has not returned to work. The physical exam dated 8-31-15 reveals that the right shoulder exam has tenderness to palpation at the subacromial space and supraspinatus with decreased range of motion noted. The myotomes C5, C6, C7, C8 and T1 are decreased secondary to pain in the right upper extremity. The requested services included Retrospective Electromyography-Nerve Conduction Velocity of the bilateral upper extremities, requested 3-23-

15 and 4-29-15, Retrospective Terocin Patches, no quantity provided requested 2-23-15, Physical Therapy, three times a week for six weeks to the right shoulder, Retrospective Acupuncture three times a week for six weeks for the right shoulder, requested 3-23-15, Retrospective Chiropractic, three times a week for six weeks for the right shoulder requested 3-23-15 and Plasma Rich Protein Injection, right shoulder. The original Utilization review dated 9-25-15 modified the request for Retrospective Electromyography-Nerve Conduction Velocity of the bilateral upper extremities, requested 3-23-15 and 4-29-15 modified to Electromyography-Nerve Conduction Velocity of the bilateral upper extremities, requested 3-23-15 with end date of service 11-23-15. The request was non-certified for Retrospective Terocin Patches, no quantity provided requested 2-23-15, Physical Therapy, three times a week for six weeks to the right shoulder, Retrospective Acupuncture three times a week for six weeks for the right shoulder, requested 3-23-15, Retrospective Chiropractic, three times a week for six weeks for the right shoulder requested 3-23-15 and Plasma Rich Protein Injection, right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Electromyography/Nerve Conduction Velocity of the bilateral upper extremities, requested 3-23-15 and 4-29-15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Neck and Upper back, Upper Extremities, EMG/NCV studies.

Decision rationale: The CA and the ODG guidelines recommend that Electromyography / Nerve Conduction Velocity (EMG / NCV) studies can be utilized for the evaluation of upper extremities radiculopathy or neurological deficits when physical examination and radiological tests are inconclusive. The records did not show radiological findings consistent with cervical spine causes of upper extremities radiculopathy and neurological deficits. The records indicate the preponderance of the subjective and objective findings is related to the shoulder condition not the cervical spine or upper extremities nerve damage. The request for Retrospective Electromyography / Nerve Conduction Velocity of the bilateral upper extremities, requested 2-23-2015 and 4-29-2015 is not medically necessary.

Retrospective Terocin Patches, no quantity provided requested 2-23-15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Capsaicin, topical, Medications for chronic pain, Salicylate topicals, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line anticonvulsant and antidepressant medications have failed. The records did not show subjective or objective findings consistent with a diagnosis of localized neuropathic pain such as CRPS. There is no documentation of failure of treatment with orally administered first line medications. The guidelines recommend that topical medications be utilized in individual formulations for evaluation of efficacy. The Terocin product contains menthol 10% / lidocaine 2.5% / capsaicin 0.025% / methyl salicylate 25%. There is lack of guidelines support for the utilization of menthol and methyl salicylate for the treatment of chronic musculoskeletal pain. The request for the Retrospective use of Terocin patches requested 2-23-2015 is not medically necessary.

Physical Therapy, three times a week for six weeks to the right shoulder: Upheld

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

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical treatments can be utilized for the management of exacerbation of musculoskeletal pain when standard NSAIDs, behavioral modifications and exercise have failed. The utilization of physical treatment can result in reduction in medications use, increased range of motion and functional restoration. The guidelines recommend that patients proceed to a home exercise program after completion of supervised physical treatments. The records indicate that the patient have previously completed sessions of supervised physical treatments. There is no documentation of a recent re-injury of exacerbation of the right shoulder condition. The request for Physical Therapy, three times a week for 6 weeks to the right shoulder is not medically necessary.

Retrospective Acupuncture three times a week for six weeks for the right shoulder, requested 3-23-15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary, and Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Acupuncture.

Decision rationale: The CA MTUS and the ODG guidelines recommend that acupuncture treatments can be utilized for the management of exacerbation of musculoskeletal pain when standard NSAIDs, behavioral modifications and exercise have failed. The utilization of acupuncture treatments can result in reduction in medications use, increased range of motion and functional restoration. The records indicate that the patient have previously completed

sessions of acupuncture treatments. There is no documentation of a recent re-injury of exacerbation of the right shoulder condition. The request for Retrospective Acupuncture treatments three times a week for 6 weeks for the right shoulder requested 3-23-2015 is not medically necessary.

Retrospective Chiropractic, three times a week for six weeks for the right shoulder requested 3-23-15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Work-Relatedness, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation, Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Shoulder, Chiropractic Treatments.

Decision rationale: The CA MTUS and the ODG guidelines recommend that physical treatments can be utilized for the management of exacerbation of musculoskeletal pain when standard NSAIDs, behavioral modifications and exercise have failed. The utilization of physical treatments can result in reduction in medications use, increased range of motion and functional restoration. The guidelines recommend that patients proceed to a home exercise program after completion of supervised physical treatments. The records indicate that the patient have previously completed sessions of chiropractic physical treatments. There is no documentation of a recent re-injury of exacerbation of the right shoulder condition. The request for Retrospective Chiropractic treatments, three times a week for 6 weeks to the right shoulder requested 3-23- 2015 is not medically necessary.

Plasma Rich Protein Injection, right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Platelet-rich plasma.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Shoulder.

Decision rationale: The CA MTUS and the ODG guidelines recommend that interventional pain procedures can be utilized for the treatment of severe musculoskeletal pain when conservative treatment with medications, PT and exercise have failed. There is lack of guidelines support for the use of Plasma Rich Protein injections because of insufficient data supporting sustained beneficial effect or functional restoration from the injections. The records did not show that the patient have failed conservative treatments with medications or standard steroid injections. The request for Plasma Rich Protein injection to right shoulder is not medically necessary.