

Case Number:	CM15-0050981		
Date Assigned:	03/24/2015	Date of Injury:	03/04/2014
Decision Date:	05/13/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/17/2015

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, Washington 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 60-year-old female who reported an injury on 03/04/2014. The mechanism of injury was cumulative trauma. Prior therapies included physical therapy and medications. There was no Request for Authorization submitted for review. The documentation of 12/29/2014 revealed the injured worker had complaints of neck pain, left shoulder pain, low back pain, and bilateral knee pain that was burning. The injured worker indicated medications offered temporary pain relief and improved her ability to sleep. The physical examination revealed tenderness to palpation over the cervical paraspinals bilaterally. The range of motion of the cervical spine was decreased. The inspection of the left shoulder revealed tenderness to palpation in the upper trapezius and rhomboid muscles. The injured worker had decreased range of motion of the bilateral shoulders. Sensation to pinprick and light touch was diminished at C5-T1 dermatomes bilaterally. Motor strength was 4/5. There was tenderness to palpation in the lumbar paraspinal muscles and over the lumbosacral junction. The injured worker had decreased range of motion of the lumbar spine. The examination of the bilateral knees revealed tenderness to palpation of the medial and lateral joint line into the patellofemoral joint bilaterally. The injured worker had decreased range of motion in flexion. The injured worker had decreased sensation to pinprick and light touch at L4-S1 dermatomes bilaterally. Motor strength was 4/5 in the bilateral lower extremity muscle groups. The diagnosis included cervical spine sprain and strain; lumbar spine sprain and strain; bilateral knee sprain and strain; bilateral knee osteoarthritis; and left shoulder bursitis, tendinitis, AC arthrosis, rotator cuff tear, and labral tear; as well as cervical radiculopathy, low back pain, and lumbar radiculopathy. The treatment plan included a continuation of physical therapy, chiropractic care, and acupuncture for the cervical spine, left shoulder, lumbar spine, and right and left knee at a frequency of 3 times per week for 6 weeks and continuation of shockwave therapy 3 treatments for the left shoulder and right and left knee and 6

treatments for the cervical spine and lumbar spine, as well as Terocin patches for pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 x 6, Cervical, Left Shoulder, Lumbar Spine, Right/Left Knees: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend up to 10 visits of physical medicine for the treatment of myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical medicine treatment. There was lack of documentation of objective functional benefit that was received and the quantity of sessions attended. There was a lack of documentation of remaining objective functional deficits. The quantity of sessions previously attended was not provided. 18 sessions would be excessive. Given the above, the request for Physical Therapy 3 x 6, Cervical, Left Shoulder, Lumbar Spine, Right/Left Knees is not medically necessary.

Acupuncture 3 x 6, Cervical Spine, Left Shoulder, Lumbar Spine, Right/Left Knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that acupuncture is used as an option when pain medication is reduced or not tolerated. The time to produce functional improvement is 3 to 6 treatments and acupuncture treatments may be extended with functional improvement as documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review indicated the injured worker had previously attended acupuncture. There was a lack of documentation of clinically significant improvement. The request for 18 sessions would be excessive. Given the above, the request for Acupuncture 3 x 6, Cervical Spine, Left Shoulder, Lumbar Spine, Right/Left Knees is not medically necessary.

Continue Shockwave Therapy up to 3 treatments for the Left Shoulder and Right/Left Knees: 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) TWC shoulder Procedures, TWC Knee and Leg.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Other Medical Treatment Guideline

or Medical Evidence: Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that some medium quality evidence supports extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. The referenced guidelines do not address extracorporeal shockwave therapy for the knees, neither does ODG. As such, tertiary guidelines were sought. Per Wang, Ching-Jen (2012), "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." There was a lack of documentation of objective functional benefit that was received and the quantity of sessions previously attended. Additionally, there was a lack of documentation to support the necessity for a continuation of shockwave therapy as it is not recommended per the referenced literature and guidelines. There was a lack of documentation indicating the injured worker had calcifying tendinitis. Given the above, the request for Continue Shockwave Therapy up to 3 treatments for the Left Shoulder and Right/Left Knees is not medically necessary.

Continue Shockwave Therapy up to 6 treatments for the Cervical Spine and Lumbar Spine: 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) TWC Low Back Procedures.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Shockwave Therapy and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: The Official Disability Guidelines indicate that shockwave therapy for the lumbar spine is not recommended. They do not address the cervical spine. As such, tertiary guidelines were sought. Per Wang, Ching-Jen (2012), "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guidelines recommendations. Additionally, there was a lack of documentation indicating a necessity to support continued cervical spine extracorporeal shockwave therapy. There was a lack of documentation of an objective decrease in pain and objective functional benefit that was received from prior therapy and the quantity of sessions. Given the above, the request for Continue Shockwave Therapy up to 6 treatments for the Cervical Spine and Lumbar Spine is not medically necessary.

Terocin Patches: Upheld

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

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 the injured worker had 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 frequency, quantity, and body part to be treated with the requested medication. Given the above, the request for Terocin patches is not medically necessary. There was a lack of documented strength for the requested medication.