

Case Number:	CM15-0085585		
Date Assigned:	05/07/2015	Date of Injury:	09/15/2011
Decision Date:	06/26/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	05/04/2015

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 48-year-old female who sustained an industrial injury on 09/15/11. Initial complaints and diagnoses are not available. Treatments to date include medications. Diagnostic studies include x-rays. Current complaints include back pain radiating to the right leg, right shoulder/arm/hand/wrist, and hip pain. Current diagnose include lumbosacral musculoligamentous strain/sprain with radiculitis, lumbosacral spine discogenic disease, right shoulder sprain/strain, and tendinitis, right wrist sprain/strain, right 2nd finger tenosynovitis, right hip internal derangement with subluxation. In a progress note dated 03/25/15 the treating provider reports the plan of care as Terocin patches, hot/cold unit/, and a Synvisc injection to the right shoulder. The requested treatments are Terocin patches, hot/cold unit/, and a Synvisc injection to the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder Synvisc injection: 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 (Acute and Chronic).

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, Hyaluronic acid injections.

Decision rationale: Regarding the request for Synvisc injections, California MTUS does not address the issue. ODG supports hyaluronic acid injections are not recommended for the shoulder. Within the documentation available for review, there is no documentation of peer reviewed scientific literature supporting the use of Synvisc injections in the treatment of the shoulder. In the absence of such documentation, the currently requested Synvisc injections are not medically necessary.

Hot Cold Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for a hot/cold unit, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested hot/cold unit. Finally, there is no statement indicating why the patient would be unable to use low-tech at-home applications of heat and cold to address any current issues. In the absence of clarity regarding those issues, the currently requested hot/cold unit is not medically necessary.

12 physical therapy visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for 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 no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the ODG as a trial if no therapy has been provided previously. If therapy has been provided previously, there is no documentation of objective functional improvement as a result of those therapy sessions. In the absence of such documentation, the current request for physical therapy is not medically necessary.

Terocin patches quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, topical; Capsaicin, topical; Salicylate topicals.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

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 nonsteroidal 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.