

<b>Case Number:</b>	CM14-0117599		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/06/2014
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records, presented for review, indicate that this 25-year-old male was reportedly injured on June 6, 2014. The mechanism of injury was noted as repetitive overuse and lifting. The most recent progress note, dated June 9, 2014, indicated that there were ongoing complaints of bilateral shoulder pain and low back pain. The physical examination demonstrated tenderness and muscle spasm in the trapezius, deltoid and shoulder musculature. There was tenderness over the acromioclavicular joint of the right as well as a decreased range of motion to both shoulders. Diagnostic imaging studies were pending. Previous treatment included initial clinical evaluation of medications. A request had been made for physical therapy, chiropractic care and radiographs and Electromyography (EMG)/Nerve Conduction Velocity (NCV) and medication and was denied in the pre-authorization process on July 2, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy two (2) times a week, up to twenty-four (24) visits: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering, and the Restoration of Function Chapter, page 114; Official Disability Guidelines (ODG) Shoulder Chapter; <http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines>

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

**Decision rationale:** As outlined in the ACOEM guidelines, if treatment response is inadequate, i.e. that symptoms pursue after a home exercise protocol, then formal physical therapy can be initiated. Therefore, there is no clinical indication presented for 24 sessions of physical therapy, until there is an assessment of the efficacy of a home exercise protocol. Therefore, this is not medically necessary.

**Chiropractic treatment including cold packs, diathermy, EMS, massage, and ultrasound, three (3) times a week, up to twenty-four (24) visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**Decision rationale:** When noting the date of injury, the mechanism of injury, the injury sustained, and that physical therapy is being initiated, there is no indication for chiropractic care at the same time. Therefore, there is insufficient data to support the clinical indication or medical necessity of such an intervention.

**X-rays bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Radiography, Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** As outlined in the ACOEM guidelines, there is support for plain radiographs of the shoulders in subacute or chronic situations, after appropriate conservative treatment has been provided, and there is no noted improvement. Given that the treatment protocol has not initiated, the request is premature. This is not medically necessary.

**Electromyography (EMG) bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Acupuncture Treatment Guidelines.

**Decision rationale:** MTUS/ACOEM Guidelines support NCS in patients with clinical signs of carpal tunnel syndrome and who may be candidates for surgery, but EMG is not generally

necessary. After review of the available medical records, the claimant has no indication of any compressive neuropathy either on the mechanism of injury or with the physical examination. Therefore, this test is not clinically indicated based on the medical information presented for review.

**Nerve Conduction Velocity (NCV) bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, tanle 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**Decision rationale:** MTUS/ACOEM Guidelines support NCS in patients with clinical signs of carpal tunnel syndrome AND who may be candidates for surgery, but EMG is not generally necessary. After review of the available medical records, the claimant has no indication of any compressive neuropathy either on the mechanism of injury or with the physical examination. Therefore, this test is not clinically indicated based on the medical information presented for review.

**Menthoderm gel 240 grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/mentoderm-cream.html>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or Capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for Mentoderm is not medically necessary.