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| <b>Case Number:</b>   | CM14-0146847 |                              |            |
| <b>Date Assigned:</b> | 12/11/2014   | <b>Date of Injury:</b>       | 04/08/2010 |
| <b>Decision Date:</b> | 02/05/2015   | <b>UR Denial Date:</b>       | 09/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/09/2014 |

### 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 Rehab, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 61 year old male with an injury date of 04/08/10. Based on the 07/01/14 progress report provided by treating physician, the patient complains of right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. Per follow up orthopedic surgical report dated 05/29/14, patient is status post right rotator cuff repair 04/04/14. Physical examination on 07/01/14 revealed pain to bilateral upper extremities, and tenderness to upper trapezius with moderate impairment in range of motion. Physical examination to the right shoulder on 05/29/14 revealed healed incision at the site of intervention and decreased range of motion in flexion and abduction. Urine drug screen dated 05/30/14 detected Amytryptiline, Tramadol, and Hydrocodone. Physical therapy notes from 04/14/14 to 07/14/14 show patient attended 16 sessions. Acupuncture report dated 07/28/14 shows recommended frequency of 2 x 6 weeks. Per Functional Capacity Evaluation dated 07/30/14, the patient meets the strength requirements assigned to his occupation as a welder and is recommended to work with restrictions. Per progress report dated 02/15/13, patient takes Hydrocodone for pain and Pantoprazole for gastritis. Medications not discussed in other reports submitted for review, which were handwritten and difficult to interpret, especially 07/01/14. Diagnosis 05/29/14- lumbosacral radiculopathy- shoulder impingement- elbow tendinitis/bursitis- carpal tunnel syndrome- meniscal tear medialDiagnosis 07/01/14- right shoulder impingement- left wrist, carpal tunnel syndrome- left elbow, bursitis, tendinitis- left knee, post surgery, positive meniscus tear/degenerative joint diseaseThe utilization review determination being challenged is dated 08/18/14. Treatment reports were provided from 02/15/13 - 08/15/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Infrared, massage, myofascial release, iontophoresis, electro stimulation 2-3 x wk x 4 weeks for shoulder/arm sprain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Iontophoresis

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for INFRARED, MASSAGE MYOFASCIAL RELEASE, IONTOPHORESIS, ELECTROSTIMULATION 2-3 X WK X 4WEEKS FOR SHOULDER/ARM SPRAIN. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Iontophoresis states: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. (Thomas, 2006)." ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tarnier, 2012)" ODG-TWC, Carpal Tunnel Syndrome (Acute & Chronic) Chapter, under Corticosteroids, oral states: "Under study. For patients with mild to moderate CTS who opt for conservative treatment, studies show that corticosteroids may be of greater benefit than NSAIDs, but side effects prevent their general recommendation. (Wong, 2001)" Patient's right rotator cuff repair surgery is dated 04/04/14, and UR review date is 09/02/14. Treating physician does not explain reason for this multiple request other than for subjective pain. Regarding Infrared massage and Iontophoresis, ODG does not recommend infrared over other heat therapies; and iontophoresis is not recommended due to ineffectiveness. There is discussion why patient needs formalized therapy and cannot move on to home exercise program. There is no discussion of flare-up's or new injury to the shoulder to warrant additional treatment. Furthermore, the request for 8-12 visits would exceed the amount of sessions allowed by guidelines. Therefore, the request IS NOT medically necessary.

**EMG 1 extremity and somatosensory upper extremity EMG/NCV for shoulder:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for EMG/NCV TO THE UPPER EXTREMITY. ACOEM Practice Guidelines,

2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Treating physician has not provided reason for the request. However, given the patient's upper extremity symptoms, physical examination findings, diagnosis and ACOEM discussion, EMG/NCV studies would appear reasonable. There is no evidence that this patient has had prior upper extremity EMG/NCV studies done. Therefore the request IS medically necessary.

**Retro: Mentherm 360mg, DOS: 7/1/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Salicylate Topical Page(s): 111-113, 105.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for RETRO: MENTHODERM 360MG DOS 7/1/2014. Regarding topical analgesics, MTUS, pg. 111-113, Topical Analgesics state they are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and recommends for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Methyl salicylate and menthol are recommended under MTUS "Salicylate topical" section, pg. 105 in which "Ben-Gay" (which contains menthol and methyl salicylate) is given as an example and is stated as significantly better than placebo in chronic pain. MTUS has support for methyl salicylate under the Topical Salicylate section for peripheral joint arthritis/tendinitis condition. Treating physician has not provided reason for the request. Though patient presents with knee, elbow and wrist symptoms for which the requested gel would be indicated, treating physician has not indicated which body part would be addressed. Topical NSAIDs are not indicated for spinal, shoulder conditions, which the patient also presents with. Furthermore, it is not known whether patient has tried the requested topical and with what efficacy. Therefore the request IS NOT medically appropriate.

**Retro: Hydrocodone/APAP #90, DOS 7/1/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 88, 89, 76-78.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications.

The request is for RETRO HYDROCODONE/APAP #90 DOS 7/1/2014. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Per progress report dated 02/15/13, patient takes Hydrocodone for pain and Pantoprazole for gastritis. Medications are not discussed in other reports submitted for review, which were handwritten and difficult to interpret, especially 07/01/14 report. Urine drug screen dated 05/30/14 detected Amitriptyline, Tramadol, and Hydrocodone. In this case, treating physician has not stated how Hydrocodone reduces pain and significantly improves patient's activities of daily living; the four A's are not specifically addressed including discussions regarding adverse effects, aberrant drug behavior and specific ADL's, etc. There are no CURES or opioid pain contracts. There is no discussion of return to work or change in work status. Given the lack of documentation as required by MTUS, the request IS NOT medically necessary.

**Retro: Omeprazole 30mg, #30, DOS 7/1/2014: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 69.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for RETRO: OMEPRAZOLE 30MG #30 DOS 7/1/14. Regarding NSAIDs and GI/CV risk factors, MTUS requires determination of risk for GI events including age >65; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. MTUS pg. 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Treating physician has not provided reason for the request. Per progress report dated 02/15/13, patient takes Hydrocodone for pain and Pantoprazole for gastritis. Medications not discussed in other reports submitted for review, which were handwritten and difficult to interpret, especially 07/01/14. Urine drug screen dated 05/30/14 detected Amitriptyline, Tramadol, and Hydrocodone. In review of medical records, patient is not on NSAID therapy to warrant prophylactic use of PPI, and there is no GI risk assessment as required by MTUS. Therefore the request 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 Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): 13.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for ACUPUNCTURE. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: "(i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months(D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)."Treating physician has not provided reason for the request. Acupuncture report dated 07/28/14 shows recommended frequency of 2 x 6 weeks. MTUS requires documentation of functional improvement, defined by labor code 9792.20(e) as significant change in ADL's, or change in work status AND reduced dependence on other medical treatments. In this case, treating physician has not documented functional improvement through discussions regarding ADL's, change in work status and reduction in medication use, for example. Therefore the request IS NOT medically necessary.

**Infrared, massage myofascial release, iontophoresis, electro stimulation 2-3 x wk x 4 weeks for knee and leg sprain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**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 - Lumbar & Thoracic (Acute & Chronic) Chapter, under Infrared therapy (IR) Neck and Upper Back (Acute & Chronic) Chapter states: "Massage therapy, Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for INFRARED, MASSAGE MYOFASCIAL RELEASE, IONTOPHORESIS, ELECTRO- STIMULATION 2-3 X WK X 4 WEEKS FOR KNEE AND LEG PAIN. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Infrared therapy (IR) states: "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise)."MTUS page 60 supports massage therapy as an adjunct to other recommended treatment such as exercise and states that it should be limited to 4-6 visits in most cases. ODG Guidelines, Neck and Upper Back (Acute & Chronic) Chapter states: "Massage therapy: recommended frequency and duration of treatment for massage therapy are the same as Manipulation: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks."ODG-TWC, Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis states: "Recommended for specific conditions as indicated below. During iontophoresis, an electric current helps deliver ionically charged substances through the skin to reach deeper tissues. Therefore, it may be indicated for calcific tendinopathy, inflammatory conditions, or hyperhidrosis. Compared with usual care,

iontophoresis is associated with improved outcomes in patients with myositis ossificans. Contraindications to use of iontophoresis include allergy or sensitivity to the substance being applied, open wounds, or impaired sensation. Iontophoresis also should not be used in the immediate vicinity of metallic implants, wires, or staples. (Rand, 2007)"Treating physician does not explain reason for this multiple request other than for subjective pain. Regarding Infrared massage and Iontophoresis, ODG does not recommend infrared over other heat therapies; and iontophoresis is not recommended due to ineffectiveness. There is discussion why patient needs formalized therapy and cannot move on to home exercise program. There is no discussion of flare-up's or new injury to the shoulder to warrant additional treatment. Furthermore, the request for 8-12 visits would exceed the amount of sessions allowed by guidelines. Therefore, the request IS NOT medically necessary.

**Infrared, massage, myofascial release iontophoresis, electro stimulation 2-3 x wk x 4 weeks for wrist strain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60, 61. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Infrared therapy (IR), Neck and Upper Back (Acute & Chronic) Chapter states: Massage therapy Shoulder (Acute & Chronic) Chapter, under Iontophoresis

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for INFRARED, MASSAGE MYOFASCIAL RELEASE, IONTOPHORESIS, ELECTROSTIMULATION 2-3 X WK X 4 WEEKS FOR WRIST STRAIN. Patient's diagnosis on 07/01/14 included right shoulder impingement; left wrist, carpal tunnel syndrome; left elbow, bursitis, tendinitis; and positive meniscus tear/degenerative joint disease. Physical examination on 07/01/14 revealed pain to bilateral upper extremities, and tenderness to upper trapezius with moderate impairment in range of motion. Urine drug screen dated 05/30/14 detected Amitriptyline, Tramadol, and Hydrocodone. Per progress report dated 02/15/13, patient takes Hydrocodone for pain and Pantoprazole for gastritis. Medications not discussed in other reports submitted for review, which were handwritten and difficult to interpret, especially 07/01/14. Acupuncture report dated 07/28/14 shows recommended frequency of 2 x 6 weeks. Physical therapy notes from 05/19/14 to 07/14/14 show patient attended 16 sessions post-operatively for the shoulder. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Infrared therapy (IR) states: "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise)." MTUS page 60 supports massage therapy as an adjunct to other recommended treatment such as exercise and states that it should be limited to 4-6 visits in most cases. ODG Guidelines, Neck and Upper Back (Acute & Chronic) Chapter states: "Massage therapy: recommended frequency and duration of treatment for massage therapy are the same as Manipulation: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-

8 weeks."ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Iontophoresis states: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. (Thomas, 2006)." Treating physician does not explain reason for this multiple request other than for subjective pain. Regarding Infrared massage and Iontophoresis, ODG does not recommend infrared over other heat therapies; and iontophoresis is not recommended due to ineffectiveness. There is discussion why patient needs formalized therapy and cannot move on to home exercise program. There is no discussion of flare-up's or new injury to the shoulder to warrant additional treatment. Furthermore, the request for 8-12 visits would exceed the amount of sessions allowed by guidelines. Therefore, the request IS NOT medically necessary.

**Infrared, massage, myofascial release iontophoresis, electro stimulation 2-3 x wk x 4 weeks for sprain (unspecified area): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis Pain (Chronic) Chapter, under Oral corticosteroids

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for INFRARED, MASSAGE MYOFASCIAL RELEASE, IONTOPHORESIS, ELECTROSTIMULATION 2-3 X WK X 4WEEKS, (UNSPECIFIED AREA)ODG-TWC, Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis states: "Recommended for specific conditions as indicated below. During iontophoresis, an electric current helps deliver ionically charged substances through the skin to reach deeper tissues. Therefore, it may be indicated for calcific tendinopathy, inflammatory conditions, or hyperhidrosis. Compared with usual care, iontophoresis is associated with improved outcomes in patients with myositis ossificans. Contraindications to use of iontophoresis include allergy or sensitivity to the substance being applied, open wounds, or impaired sensation. Iontophoresis also should not be used in the immediate vicinity of metallic implants, wires, or staples. (Rand, 2007)"ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tanner, 2012) "Treating physician does not discuss reason for the request other than subjective pain. Treating physician has not documented that patient presents with calcific tendinopathy, inflammatory conditions, hyperhidrosis, or myositis ossificans, for which guidelines would indicate iontophoresis. With regards to Dexamethasone, since iontophoresis is not recommended, there would be no need for this medication. Therefore, the request IS NOT medically necessary.

**Dexamethasone Sodium Phosphate 4 mg/ml for shoulder/arm sprain: 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 (Acute & Chronic) Chapter, under Iontophoresis Pain (Chronic) Chapter, under Oral corticosteroids

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for DEXAMETHAZONE SODIUM PHOSPHATE 4MG/ML FOR SHOULDER/ARM SPRAIN. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Iontophoresis states: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. (Thomas, 2006)." ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tanner, 2012)" Patient's right rotator cuff repair surgery is dated 04/04/14, and UR review date is 09/02/14. Treating physician does not explain reason for the request other than subjective pain. According to guidelines, iontophoresis is not recommended due to ineffectiveness. With regards to Dexamethasone, since iontophoresis is not recommended, there would be no need for this medication. Therefore, the request IS NOT medically necessary.

**Dexamethasone sodium phosphate 4mg/ml for knee and leg sprain:** 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) Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis, Pain in (Chronic) Chapter, under Oral corticosteroids

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for DEXAMETHAZONE SODIUM PHOSPHATE 4MG/ML FOR KNEE AND LEG SPRAIN. ODG-TWC, Knee & Leg (Acute & Chronic) Chapter, under Iontophoresis states: "Recommended for specific conditions as indicated below. During iontophoresis, an electric current helps deliver ionically charged substances through the skin to reach deeper tissues. Therefore, it may be indicated for calcific tendinopathy, inflammatory conditions, or hyperhidrosis. Compared with usual care, iontophoresis is associated with improved outcomes in patients with myositis ossificans. Contraindications to use of iontophoresis include allergy or sensitivity to the substance being applied, open wounds, or impaired sensation. Iontophoresis also should not be used in the immediate vicinity of metallic implants, wires, or staples. (Rand, 2007)" ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on

the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tarner, 2012) "Treating physician does not explain reason for the request other than subjective pain. There is no documentation that patient presents with calcific tendinopathy, inflammatory conditions, hyperhidrosis, or myositis ossificans, for which iontophoresis would be indicated by guidelines. Since iontophoresis is not indicated, there would be no need for Dexamethasone. Therefore, the request IS NOT medically necessary.

**Dexamethasone Sodium Phosphate 4 mg/ ml for wrist strain: 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 (Acute & Chronic) Chapter, under Iontophoresis; Pain (Chronic) Chapter, under Oral corticosteroids

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for DEXAMETHAZONE SODIUM PHOSPHATE 4MG/ML FOR WRIST STRAIN. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Iontophoresis states: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. (Thomas, 2006)." ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tarner, 2012) "Treating physician does not explain reason for the request other than subjective pain. According to guidelines, iontophoresis is not recommended due to ineffectiveness. Since iontophoresis is not recommended, there would be no need for Dexamethasone. Therefore, the request IS NOT medically necessary.

**Dexamethasone Sodium Phosphate 4 mg/ ml for sprain (unspecified area): 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) Pain (Chronic) Chapter, under Oral corticosteroids; Shoulder (Acute & Chronic) Chapter, under Iontophoresis.

**Decision rationale:** The patient presents with right shoulder pain rated 5/10, left wrist pain rated 3/10, left elbow pain rated 4/10 and left knee pain rated 5/10 without, and 2/10 with medications. The request is for DEXAMETHAZONE SODIUM PHOSPHATE 4MG/ML FOR (UNSPECIFIED AREA) ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Iontophoresis states: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. (Thomas, 2006)." ODG-TWC, Pain (Chronic) Chapter, under Oral corticosteroids

states: "Not recommended for chronic pain, except for Polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tanner, 2012) "Treating physician does not explain reason for the request other than subjective pain. According to guidelines, iontophoresis is not recommended due to ineffectiveness. Since iontophoresis is not recommended, there would be no need for Dexamethasone. Therefore, the request IS NOT medically necessary.