

Case Number:	CM14-0216915		
Date Assigned:	01/06/2015	Date of Injury:	06/26/2013
Decision Date:	02/28/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/26/2014

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. 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

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 58-year-old female with an injury date of 06/26/13. Based on the 11/19/14 progress report provided by treating physician, the patient complains of right shoulder pain rated 04/10 with the use of medication, right knee pain, and neck pain that radiates down to the shoulder blade. Physical examination to the bilateral paraspinal muscle on 11/19/14 revealed tenderness to palpation. Per progress report dated 06/26/14, there was tenderness along the knee mostly laterally with good range of motion. The EMG results on 10/08/14 were normal. Per progress report dated 05/15/14, patient is status-post surgery performed on 07/12/13 to repair the proximal left humerus fracture. There is a record of a CT scan (unspecified date) of right arm in the post-operative period. The patient treatments included, hot and cold wraps, TENS unit, and 14 visits of physical therapy yet patient reportedly never recovered her shoulder range of motion. Patient's pertinent medications included Lidopro ointment, Terocin patches, Tramadol ER, and Naproxen. Lidopro ointment and Terocin patches were first included in the progress report dated 06/26/14. Per progress report dated 11/19/14, treater states that the repeat MRIs are for diagnostic and treatment purposes and PT sessions for the shoulder are to improve range of motion, function, and strength. Patient is now retired. Diagnosis 11/19/14- Pain in joint, shoulder region, late effect of fracture of upper extremities, Discogenic cervical condition with facet inflammation now covered and the radicular component down the right upper extremity, Impingement syndrome of the shoulder on the left with adhesive capsulitis, Right knee sprain with patellofemoral inflammation and knee joint inflammation, Chronic pain syndrome. The utilization review determination being challenged is dated 12/08/14. The rationale follows: 1)

mri without contrast of bilateral shoulder, neck, and right knee: There was already approval for MRI and CT on right shoulder dated 03/14. "In regards to the neck, there were no abnormalities on the exam", and "In regards to the right knee, there is no instability subjectively or on exam and no suspicion of significant pathology." 2) physical therapy to right shoulder qty: 12.00 to qty: 10.00: "...certification of 10 physical therapy sessions is recommended in accordance with guidelines, and non-certification is recommended for the remaining 2 sessions. " 3) lidopro ointment 121gm QTY: 1.00: "There is no documentation that there has been failure of first line therapy. " 4) terocin patches qty: 20.00: There is no documentation that there has been failure of first line therapy. Treatment reports were provided from 05/15/14 -12/29/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast of bilateral shoulder, neck and right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Shoulder Chapter, Magnetic resonance imaging (MRI)

Decision rationale: The patient presents with right shoulder, right knee, and neck pain that radiates down to the shoulder blade. The request is for mri without contrast of bilateral shoulder, neck, and right knee. The patient treatments included, hot and cold wraps, TENS unit, and 14 visits of physical therapy yet she reportedly never recovered her shoulder range of motion. Patient is now retired.ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, "Routine testing (laboratory test, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raise a suspicion of a serious shoulder condition or referred pain." ACOEM Guidelines page 207-208 continues to state that the primary criteria for ordering imaging studies include: Emergency red flags, Physiologic evidence of tissue insult, Failure to progress in strengthening program, Clarification of anatomy prior to an invasive procedure. ODG-TWC, Shoulder (Acute & Chronic) Chapter under Magnetic resonance imaging (MRI) states: " Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)"Per progress report dated 11/19/14, treater states that the "repeat" MRIs are for diagnostic and treatment purposes. In this case, there are no documentations or discussions regarding the previous MRIs and the associated results. In addition, upon reviewing the examination records, there are no significant changes in patient's symptoms or findings suggestive of significant pathology; hence, none of the criteria for ordering imaging studies required by ODG and ACOEM guidelines have been met. Therefore, the request is not medically necessary. ODG-TWC, Shoulder (Acute & Chronic) Chapter under Magnetic resonance imaging (MRI) states: "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)" Per progress report dated 11/19/14, treater states that the "repeat"

MRIs are for diagnostic and treatment purposes. In this case, there are no documentations or discussions regarding the previous MRIs and the associated results. In addition, upon reviewing the examination records, there are no significant changes in patient's symptoms or findings suggestive of significant pathology; hence, none of the criteria for ordering imaging studies required by ODG and ACOEM guidelines have been met. Therefore, the request IS NOT medically necessary.

Physical Therapy to right shoulder quantity (QTY) : 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Work Loss Data Institute, ODG Treatment in Workers Compensation, 5th Edition, 2007 or current year, Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: The patient presents with right shoulder, right knee, and neck pain that radiates down to the shoulder blade. The request is for physical therapy to right shoulder qty: 12.00 to qty: 10.00. The patient treatments included, hot and cold wraps, TENS unit, and 14 visits of physical therapy yet she reportedly never recovered her shoulder's range of motion. Patient is now retired. MTUS pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 05/15/14, patient states she has had 14 PT sessions but never regained the shoulder's normal range of motion. Treater is requesting 12 additional sessions of physical therapy to the right shoulder to improve range of motion, function, and strength. In this case, treater does not explain why on-going therapy is needed despite the lack of efficacy with previous PT treatments and why the patient is unable to transition into a home exercise program. Furthermore, current request for 12 sessions combined with what was already authorized exceeds what is recommended by MTUS. Therefore, the request is not medically necessary.

Lidopro Ointment 121 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: The patient presents with right shoulder pain rated 04/10 with the use of medication, right knee pain, and neck pain that radiates down to the shoulder blade. The request is for lidopro ointment 121gm qty: 1.00. Patient's pertinent medications included Lidopro ointment, Terocin patches, Tramadol ER, and Naproxen. Lidopro ointment and Terocin patches were first included in the progress report dated 06/26/14. The MTUS has the following regarding

topical creams (p111, chronic pain section): Lidocaine Indication: Neuropathic pain 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. In this case, MTUS guidelines do not allow any other formulation of Lidocaine other than in patch form. Guidelines do not recommend a compounded product if one of the compounds are not indicated for use. Therefore, the requested Lidopro ointment is not medically necessary.

Terocin Patches QTY: 20.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams,Lidodcaine Page(s): 57, 112.

Decision rationale: The patient presents with right shoulder pain rated 04/10 with the use of medication, right knee pain, and neck pain that radiates down to the shoulder blade. The request is for TEROGIN PATCHES QTY: 20.00. Patient's pertinent medications included Lidopro ointment, Terocin patches, Tramadol ER, and Naproxen. Lidopro ointment and Terocin patches were first included in the progress report dated 06/26/14. MTUS guidelines page 57 states, "topical lidocaine 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that Terocin patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, Terocin patches were first included in the progress report dated 06/26/14 and the patient has been using the medication consistently since then; however, treater does not document the area of treatment and impact on pain and function, as required by MTUS. Additionally, the EMG results on 10/08/14 were reported as normal and there is no other indication of neuropathy noted in the provided medical reports. Therefore, the request is not medically necessary.