

Case Number:	CM15-0032584		
Date Assigned:	02/26/2015	Date of Injury:	04/23/2014
Decision Date:	06/30/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	02/20/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 49 year old male, who sustained an industrial injury on 4/23/14. He has reported pain in the head, shoulders and right hip. The diagnoses have included headaches, bilateral shoulder derangement and right hip derangement. Treatment to date has included diagnostic studies and oral medications. As of the PR2 dated 1/8/15, the injured worker reports 7-6/10 burning pain in the bilateral shoulders that radiates to the arms and fingers. The treating physician noted a positive Hawkins test. The treating physician requested an MRI of the bilateral shoulders and right hip, Terocin patches, EMG/NCV of the bilateral upper and lower extremities, psychologist consultation, an injection of platelet-rich plasma to the bilateral shoulders, 3 shockwave therapy sessions to the bilateral shoulders and 3 shockwave therapy sessions to the right hip. On 2/16/15 Utilization Review non-certified a request for an MRI of the bilateral shoulders and right hip, Terocin patches, EMG/NCV of the bilateral upper and lower extremities, an injection of platelet-rich plasma to the bilateral shoulders, 3 shockwave therapy sessions to the bilateral shoulders and 3 shockwave therapy sessions to the right hip and certified a request for psychologist consultation. The utilization review physician cited the ACOEM and MTUS guidelines. On 2/20/15, the injured worker submitted an application for IMR for review of an MRI of the bilateral shoulders and right hip, Terocin patches, EMG/NCV of the bilateral upper and lower extremities, psychologist consultation, an injection of platelet-rich plasma to the bilateral shoulders, 3 shockwave therapy sessions to the bilateral shoulders and 3 shockwave therapy sessions to the right hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topical Compounds.

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

Decision rationale: MTUS guidelines state that lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. The documentation in the case file does not indicate that the IW tried any other medications without success. Even though menthol is approved for topical use this cannot be approved due to other components not being medically necessary. This request is not medically necessary and reasonable.

1 MRI of bilateral shoulders and right hip: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip/Pelvis - MRI (magnetic resonance imaging).

Decision rationale: Per ACOEM guidelines criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Per ODG guidelines, MRI of the hip is recommended for osseous, articular or soft-tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft-tissue injuries, and tumors. IW had prior right hip and bilateral shoulder MRI's in July 2014 and there was no mention of further injury, which would require repeat imaging. The request is not medically necessary.

1 EMG/NCV of the bilateral upper and lower extremities: 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), Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Low Back Chapters.

Decision rationale: According to ACOEM, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. There is no clear description of a radiculopathy; the IW describes shooting pain however, it is not described as dermatomal in pattern. Additionally, there is no clear indication that conservative measures were undertaken with regards to the neck and shoulders. According to ACOEM, for most patients presenting with true low back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. There is no clear description of a radiculopathy, the IW describes shooting pain however, it is not described as dermatomal in pattern nor do the clinical sensory findings correlate to the reported symptoms. This request is not medically necessary and appropriate.

1 PRP injection to the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder - Platelet-rich plasma (PRP).

Decision rationale: Per ODG guidelines, PRP injections are currently under study as a solo treatment. Recommend PRP augmentation as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. There is no notation of possible surgery nor findings consistent with rotator cuff tear such as locking in range of movement. The request is not medically necessary.

3 Shockwave therapy bilateral shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder - Extracorporeal shock wave therapy (ESWT).

Decision rationale: Per ACOEM, guidelines state that there is a recommendation against using extracorporeal shockwave therapy. Per ODG guidelines, ESWT is recommended for calcifying tendinitis but not for other shoulder disorders. There is no notation of calcifying tendinitis in the chart; diagnosis for the shoulder is bilateral shoulder sprain/strain. The request is not medically necessary.

3 Shockwave therapy treatment to the right hip: 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) Ankle, Knee/Leg, Elbow - Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS and ODG do not comment on ESWT of the hip. ODG guidelines for the ankle were the most applicable to the hip. These guidelines state that ESWT is not recommended using high energy ESWT. Recommended using low energy ESWT as an option for chronic plantar fasciitis. With regards to the leg, ESWT is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. Additionally, ODG guidelines for the elbow state that ESWT is not recommended. If the decision is made to use this treatment despite the lack of convincing evidence criteria for use are that the condition has remained despite six months of standard treatment, at least three conservative treatments have been performed prior to use of ESWT. These would include: (a) Rest; (b) Ice; (c) NSAIDs; (d) Orthotics; (e) Physical Therapy; (e) Injections (Cortisone), maximum of 3 therapy sessions over 3 weeks and contraindications are patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. According to the documentation, the IW was undergoing physical therapy and thus the request is not medically necessary.