

Case Number:	CM14-0047274		
Date Assigned:	07/02/2014	Date of Injury:	10/28/2011
Decision Date:	09/17/2014	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/15/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 58-year-old female who reported an injury on 10/28/2011. The mechanism of injury was not provided. On 01/07/2014, the injured worker presented with bilateral shoulder and right wrist pain. Upon examination of the left shoulder, there was painful range of motion and +3 tenderness to palpation of the anterior shoulder, lateral shoulder and the posterior shoulder. The supraspinatus press was positive. Examination of the right shoulder revealed decreased painful range of motion. Examination of the right wrist noted painful range of motion and +3 tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, and volar wrist with positive Phalen's. The diagnoses were left shoulder impingement syndrome, left shoulder sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, status post surgery of the right shoulder, right carpal tunnel syndrome, right wrist internal derangement, right wrist sprain/strain, elevated blood pressure, and hypertension. Prior therapy included medications. The provider recommended additional chiropractic sessions 2 times a week for 4 weeks for the left shoulder and a Sudoscan, the provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional chiropractic session 2 times weekly for 4 weeks for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

Decision rationale: The California MTUS Guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to particular activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of functional improvement a total of up to 18 visits for up to 6 to 8 weeks. There is lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. Additionally, the provider's request for chiropractic sessions 2 times weekly for 4 weeks exceeds the guideline recommendations. The request for additional chiropractic sessions 2 times weekly for 4 weeks for the left shoulder is not medically necessary.

Sudoscan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna's clinical policy bulletin, Policy # 0485, Autonomic testing/sudo motor testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: SUDOSCAN Device for the Early Detection of Diabetes: In Vitro Measurement versus Results of Clinical Tests Sensor Letters, Volume 9, Number 6, December 2011, pp. 2147-2149(3) American Scientific Publishers.

Decision rationale: Scientific base research state that Sudoscan is recommended for diagnosis of sudomotor dysfunction and detection of diabetes in an early stage. The provider's rationale for the request of a Sudoscan was not provided. There is no information on how a Sudoscan will aid the provider in an evolving treatment plan for the injured worker. As such, the request is not medically necessary.