

Case Number:	CM15-0132448		
Date Assigned:	07/20/2015	Date of Injury:	10/15/2013
Decision Date:	08/25/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/08/2015

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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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:

This 50 year old male sustained an industrial injury to the right shoulder on 10/15/13. The injured worker underwent right shoulder arthroscopy with subacromial decompression and mini-open rotator cuff repair on 4/3/14. The injured worker received postoperative physical therapy, chiropractic therapy and medications. Magnetic resonance imaging right shoulder (4/5/15) showed acromioclavicular osteoarthritis and supraspinatus and infraspinatus tendinosis. In a PR-2 dated 6/1/15, the injured worker complained of right shoulder pain rated 4/10 that increased when working. Physical exam was remarkable for right shoulder with tenderness to palpation at the acromioclavicular joint and rotator cuff with decreased range of motion and positive impingement. Current diagnoses included right shoulder rotator cuff tear status post repair. The treatment plan included acupuncture twice a week for four weeks, a referral to orthopedics, a urinalysis, functional improvement measures, a referral for electric shockwave therapy and prescriptions for topical compound creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture two times four weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, the current request for a visit exceeds the 6-visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

Functional improvement measurement with functional improvement measures: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for Functional improvement measurement with functional improvement measures, It is unclear what type of functional improvement measurements with functional improvement measures is being requested. Since treating providers usually do functional assessments routinely during the office visit, screening for improvements. However, Functional capacity evaluation is discussed in guidelines. Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity

regarding those issues, the currently requested Functional improvement measurement with functional improvement measures is not medically necessary.

Shockwave for the right shoulder: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shockwave Therapy (ESWT).

Decision rationale: Regarding the request for shockwave therapy of the right shoulder, ODG recommend Shockwave therapy (ESWT) for calcifying tendinitis but not for other shoulder disorders. In treating calcifying tendonitis, both high-energy and low-energy ESWT provide a beneficial effect on shoulder function, as well as on self-rated pain and diminished size of calcifications, but high-energy ESWT appears to be superior to low-energy ESWT. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions. The criteria for use of ESWT includes: Patients whose pain from calcifying tendinitis of the shoulder 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); Contraindicated in Pregnant women; Patients younger than 18 years of age; 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. Within the documentation available for review, there is no identification of a diagnosis of right shoulder calcifying tendinitis. As such, the current request for shockwave therapy of the right shoulder is not medically necessary.

Urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99 of 127.

Decision rationale: Regarding the request for a urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of current risk stratification to identify the medical necessity of drug screening. Additionally, there

is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested urine toxicology test is not medically necessary.