

<b>Case Number:</b>	CM15-0190905		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	11/08/2014
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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, California

Certification(s)/Specialty: Emergency 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 female who sustained an industrial injury on 11-8-14. The injured worker reported pain in the neck, right shoulder and wrist. A review of the medical records indicates that the injured worker is undergoing treatments for cervical disc protrusion, cervical myospasms, right shoulder impingement syndrome, right shoulder myofascitis and right wrist pain. Medical records dated 9-3-15 indicate pain rated at 8 out of 10. Provider documentation dated 9-3-15 noted the work status as return to work 9-3-15. Treatment has included Ketoprofen, Cyclobenzaprine, Synapryn and a magnetic resonance imaging. Objective findings dated 9-3-15 were notable for painful and decreased cervical range of motion, tenderness to palpation to the cervical paravertebral muscles, shoulder, dorsal and volar wrist. The original utilization review (9-11-15) denied a request for Acupuncture therapy 1x6, cervical spine, right shoulder and right wrist, Capsaicin patch #3, orthopedic consultation, orthopedic surgeon consultation and sleep study consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture therapy 1x6, cervical spine, right shoulder and right wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. It is not clear that any acupuncture has been performed to date. There have been repeated requests for acupuncture over the past 8 months. The UR review referenced acupuncture therapy notes. These were not available for review. According to guidelines, an initial course of acupuncture is 3-6 visits. If the current prescription is for an initial course, the prescription is for 6 visits. If there was a prior course of acupuncture, medical necessity for any further acupuncture is considered in light of "functional improvement." After completion of any prior acupuncture visits, the treating physician has not provided evidence of clinically significant improvement in activities of daily living, a reduction in work restrictions, or decreasing dependency on medical treatment. Given that the focus of acupuncture is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy and as a measure of progress. As discussed in the MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. As there is conflicting information regarding previous treatments, the request for acupuncture 6 visits is determined not medically necessary.

**Capsaicin patch #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Capsaicin, topical.

**Decision rationale:** According to Ca MTUS, Capsaicin topical treatment is "Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." The documentation supports the IW has been using this treatment for a minimum of 6 months. There is no documentation to support improvement of symptoms with the use of this medication. The request does not include the location, frequency, or intended site of application of these patches. There is little documentation of other treatments that have been trialed. Without the documentation or support of the guideline, the request is determined not medically necessary.

**Ortho consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Surgical Considerations, and Shoulder Complaints 2004, Section(s): Physical Examination, Surgical Considerations.

**Decision rationale:** The request for an orthopedic consultation is vague. It is unclear from this request what subspecialty of orthopedics is being requested. The IW has both documented shoulder and cervical medical conditions. It is unclear what condition the request is intended. With respect to spinal surgery referral, surgical spinal referral is indicated for: "Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; Failure of conservative treatment to resolve disabling radicular symptoms." The documentation does not include clear imaging or electrophysiologic evidence to support a surgical lesion. There is no detailed neurologic exam included in the records. With respect to shoulder surgery referral, surgery may or may not be indicated per guidelines, per the available records. Per the ACOEM Guidelines Pages 209-211, surgical consultation may be indicated for: Red-flag conditions (acute rotator cuff tear in a young worker, dislocation, etc). Activity limitation > 4 months plus a surgical lesion; Failure to increase ROM and strength after an exercise program plus a surgical lesion. Clear evidence of a lesion shown to benefit in the short and long term from surgical repair; the requesting physician did not describe the criteria for surgery per these guideline recommendations. There is not a complete account of the signs, symptoms, test findings, treatment results, and reasons for surgery. Without the support of the documentation, the clarity of the request, or the support of the guidelines, the request for ortho consultation is determined not medically necessary.

**Ortho surgeon consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Surgical Considerations, and Shoulder Complaints 2004, Section(s): Physical Examination, Surgical Considerations.

**Decision rationale:** The request for an orthopedic consultation is vague. It is unclear from this request what subspecialty of orthopedics is being requested. The IW has both documented shoulder and cervical medical conditions. It is unclear what condition the request is intended. With respect to spinal surgery referral, surgical spinal referral is indicated for "Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging

studies (radiculopathy), preferably with accompanying objective signs of neural compromise; Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; Failure of conservative treatment to resolve disabling radicular symptoms." The documentation does not include clear imaging or electrophysiologic evidence to support a surgical lesion. There is no detailed neurologic exam included in the records. With respect to shoulder surgery referral, surgery may or may not be indicated per guidelines, per the available records. Per the ACOEM Guidelines Pages 209-211, surgical consultation may be indicated for: Red flag conditions (acute rotator cuff tear in a young worker, dislocation, etc). Activity limitation > 4 months plus a surgical lesion; Failure to increase ROM and strength after an exercise program plus a surgical lesion. Clear evidence of a lesion shown to benefit in the short and long term from surgical repair; the requesting physician did not describe the criteria for surgery per these guideline recommendations. There is not a complete account of the signs, symptoms, test findings, treatment results, and reasons for surgery. Without the support of the documentation, the clarity of the request, or the support of the guidelines, the request for ortho consultation is determined not medically necessary.

**Sleep study consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Polysomnography and Other Medical Treatment Guidelines Practice Parameters for the Indications for Polysomnography and Related Procedures: An Update for 2005. SLEEP 2005; 28 (4): 499-521.

**Decision rationale:** The MTUS does not provide direction for evaluating or treating sleep disorders. The American Academy of Sleep Medicine (AASM) has published practice parameters for polysomnography (PSG) and related procedures. The conditions addressed included sleep related breathing disorders, other respiratory disorders, narcolepsy, parasomnias and sleep related seizure disorders, restless legs syndrome and periodic limb movement sleep disorder, depression with insomnia, and circadian rhythm sleep disorders. The initial evaluation "should include a thorough sleep history and a physical examination that includes the respiratory, cardiovascular, and neurologic systems." "The general evaluation should serve to establish a differential diagnosis of SRBDs, which can then be used to select the appropriate test(s). The general evaluation should therefore take place before any PSG is performed." The Official Disability Guidelines recommend polysomnography under some circumstances, including: "Excessive daytime somnolence; Sleep-related breathing disorder or periodic limb movement disorder is suspected; & Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended." The treating physician has not provided sufficient indications for this study in light of the published

guidelines and medical evidence. There is no evidence of a thorough medical evaluation that establishes the presence of all relevant medical conditions. The recommended prior conservative care prior to ordering a sleep study, per the Official Disability Guidelines, has not been completed. A sleep study is not medically necessary based on lack of sufficient medical evaluation and the lack of sufficient current indications.