

Case Number:	CM15-0204492		
Date Assigned:	10/21/2015	Date of Injury:	10/27/2013
Decision Date:	12/02/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/19/2015

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

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 injured worker is a 37 year old female, who sustained an industrial injury on 10-27-2013. The injured worker is undergoing treatment for lumbar disc disease and lumbar radiculopathy. Medical records dated 9-8-2015 indicate the injured worker complains of unchanged stabbing and tingling back pain rated 7 out of 10. Physical exam dated 9-8-2015 notes "sensation is decreased in the left L5 dermatome." Treatment to date has included Norco. A magnetic resonance imaging (MRI) dated 9-14-2015 indicates "a subtle broad based lateral disc protrusion on the left at L4-L5. The original utilization review dated 10-6-2015 indicates the request for 3 Sessions of Extracorporeal Shockwave Therapy, for the Left Shoulder Utilizing the EMS Swiss DolorClast ESWT Device, DNA-genetic testing and urinary drug screen (UDS) is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 Sessions of Extracorporeal Shockwave Therapy, for the Left Shoulder Utilizing the EMS Swiss DolorClast ESWT Device: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Extracorporeal shock wave therapy.

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 shockwave therapy (ESWT), pages 915-916.

Decision rationale: While extracorporeal shock wave therapy may be indicated for calcific tendinitis, there are no high-quality randomized clinical studies showing long term efficacy. ESWT may be a treatment option for calcifying tendinitis in patients with at least three failed conservative treatment trials for over six months; however, it is not recommended for chronic shoulder disorders, rotator cuff tears or osteoarthropathies, not demonstrated here. ESWT is also contraindicated in pregnant women, younger patients, and those with blood clotting diseases, active infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage, or in patients with cardiac pacemakers or those who had previous surgery. Submitted reports have not demonstrated clear diagnosis, symptom complaints or clinical findings to support for this treatment under study nor is there evidence of failed conservative trials, new acute injury or progressive deterioration in ADLs to support for the treatment outside guidelines criteria. The 3 Sessions of Extracorporeal Shockwave Therapy, for the Left Shoulder Utilizing the EMS Swiss DolorClast ESWT Device is not medically necessary or appropriate.

1 DNA/genetic Testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cytokine DNA Testing for Pain.

Decision rationale: There was no mention of indication or specifics for justification of this genetic testing. It is unclear what type of DNA testing is being requested. Cytochrome P450 tests (CYP450 tests) may be used to help determine how the body metabolizes a drug. It is conceived that genetic traits may cause variations in these enzymes, medications such as antidepressants and antipsychotics affect each person differently. By checking the DNA for certain gene variations, Cytochrome P450 tests can offer clues about how the patient respond to a particular antidepressant and antipsychotic; however, there is no identified medication prescribed. Submitted reports have not adequately demonstrated clear indication, co-morbid risk factors, or extenuating circumstances to support for non-evidence-based diagnostic DNA testing outside guidelines criteria. Per Guidelines, Cytokine DNA testing is not recommended as scientific evidence is insufficient to support its use in the diagnosis of pain. Regarding molecular testing, MTUS/ACOEM is silent on genetic testing for narcotic abuse risk; however, ODG Guidelines does not recommend genetic testing. Although there may be a genetic component to addictive behavior, current research remains experimental in terms of testing as results are inconsistent with inadequate statistics for a large range of phenotypes, using different control criteria's. Translating pharmacogenetics to clinical practice remains challenging as the context of pain, the complexity of the overall subjective nature of pain perception and response to analgesia are numerous and variable and a genetic test to tailor the opiate dosing to provide the optimal analgesia is unlikely. More studies are suggested to verify for roles of variants in addiction to

better understand effects upon different populations. ODG does state point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy or for high-risk individuals with addiction/aberrant behavior; however submitted reports have not demonstrated such criteria. Submitted reports have not adequately demonstrated the indications or documented extenuating circumstances for genetic testing outside the guidelines. Non-recommendation: The 1 DNA/genetic Testing is not medically necessary or appropriate.

1 Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, indicators for addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(Chronic) Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

Decision rationale: Per MTUS Guidelines, urine drug screening is recommended as an option before a therapeutic trial of opioids and for on-going management to differentiate issues of abuse, addiction, misuse, or poor pain control; none of which apply to this patient who has been prescribed long-term opioid for this chronic injury. Presented medical reports from the provider have unchanged chronic severe pain symptoms with unchanged clinical findings of restricted range and tenderness without acute new deficits or red-flag condition changes. Treatment plan remains unchanged with continued medication refills without change in dosing or prescription for chronic pain. There is no report of aberrant behaviors, illicit drug use, and report of acute injury or change in clinical findings or risk factors to support frequent UDS. Documented abuse, misuse, poor pain control, history of unexpected positive results for a non-prescribed scheduled drug or illicit drug or history of negative results for prescribed medications may warrant UDS and place the patient in a higher risk level; however, none are provided. The 1 Urine Drug Screen is not medically necessary or appropriate.