MAXIMUS Federal Services

Case Number:	CM15-0093700		
Date Assigned:	05/22/2015	Date of Injury:	10/07/2010
Decision Date:	09/22/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	05/14/2015

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 48-year-old female injured worker suffered an industrial injury on10/07/2010. The diagnoses included right shoulder impingement syndrome and subluxations of the biceps tendon. The diagnostics included right shoulder x-rays and magnetic resonance imaging. The injured worker had been treated with physical therapy, medications and injections. On 3/18/2015, the treating provider reported she was doing poorly with severe right shoulder pain and weakness. On exam, there were positive impingement signs with marked weakness. The treatment plan included extracorporeal shock wave therapy right shoulder wrist, Physical therapy, Right wrist brace, Urine drug screen, Acupuncture, Pain assessment and sudoscan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shock wave therapy right shoulder wrist: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Extracorporeal shockwave therapy (ESWT).

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for extracorporeal shock wave therapy right shoulder wrist. The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14. The patient is not working. ODG Guidelines, Shoulder (Acute & Chronic) Chapter, under Extracorporeal shockwave therapy (ESWT) states that ESWT is recommended for "Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment... Maximum of 3 therapy sessions over 3 weeks." ODG guidelines under the Forearm, Wrist and hand chapter provide no discussion regarding ESWT for the wrists. According to progress report 03/18/15, the patient presents with right shoulder and right wrist pain. Physical examination noted severe right shoulder pain and weakness, and positive impingement sign. Examination of the right wrist revealed tenderness, spasms and decreased ROM. The patient is s/p ulnar nerve surgery on 09/02/14 and right shoulder surgery in November of 2011. Per report 03/18/15, the patient had an X-ray of the right shoulder which showed no degenerative disease. MRI of the right shoulder showed evidence of partial thickness tear of the rotator cuff with impingement syndrome. The medical file provided for review includes no rationale for the requested ESWT for the shoulder and wrist. In this case, there is no evidence if the patient has calcifying tendinitis of the shoulder to warrant such therapy, and guidelines do not discuss ESWT for the wrists. Given there is no documentation that patient presents with calcifying tendinitis, the request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

Physical therapy one times six for the right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for Physical therapy one times six for the right wrist. The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14. The patient is outside of the post-surgical time frame. The MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." The patient was approved for 8 post-operative PT sessions on 10/17/14. There are no physical therapy reports provided for review. The exact number of completed physical therapy visits to date and the objective response to therapy were not documented in the medical reports. In this case, the requested additional 6 sessions with the 8 already received, exceeds what is recommended by

MTUS. Furthermore, the treating physician has not provided any discussion as to why the patient would not be able to transition into a self-directed home exercise program. The requested physical therapy IS NOT medically necessary.

Right wrist brace purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist Chapter under Splinting.

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for Right wrist brace purchase. The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14. Regarding wrist brace, ACOEM Chapter 11 page 265 states, "When treating with splints and CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting would be used at night and may be used during the day depending upon activity." ODG, Wrist Chapter, Splinting, states, "Recommend splinting of wrist in neutral position at night & day prn, as an option in conservative treatment." Per report 09/10/14, a right wrist brace was dispensed for post op use. Given this patient's continuing wrist complaint, the issuance of a neutral-position wrist splint could help reduce pain and improve function; however, a right wrist brace has already been dispensed and the treater provides no discussion as to why the patient requires a replacement. The request IS NOT medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Urine Drug Testing.

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for Urine drug screen. The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks of opiate users. ODG under the Pain Chapter, under Urine Drug Testing has the following: "Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results... Patients at "high risk" of adverse outcomes may require testing as often as once per month. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter." The patient has been on an opiate regimen on a long-term basis and MTUS and ODG allow for routine UDS

for opiate management. The patient had urine drug screening on 01/28/14, 03/28/14, 05/30/14, 09/10/14, 10/07/14, and 03/04/15. In this case, the treater does not state that this patient is at high risk for aberrant behavior. There is no discussion as to whether this patient is considered at risk for drug abuse/diversion necessitating such frequent screening. Without a rationale as to why this patient requires more frequent urine drug screening, or a discussion of suspected non-compliance or diversion, the requested urine drug screen cannot be substantiated. The request IS NOT medically necessary.

Acupuncture one times six for the right wrist: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Page(s): 8 of 127, 13 of 127.

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for Acupuncture one times six for the right wrist. The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14. For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. There is no discussion regarding previous Acupuncture treatments. This appears to be an initial request. This patient continues with right wrist pain. Review of the medical records did not indicate prior acupuncture treatment. Given the patient's condition, the requested 6 sessions of acupuncture appears medically reasonable and is within MTUS guidelines. Therefore, the request IS medically necessary.

Pain assessment and sudoscan ans test including cardio-respiratory ANS function and sleep study: 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) Pain (Chronic) Chapter under Autonomic nervous system function testing Pain (Chronic) chapter, regarding Polysomnography and Other Medical Treatment Guidelines www.us.impeto-medical.com/sudoscan/about-sudoscan/.

Decision rationale: This patient presents with chronic right shoulder and wrist pain. The current request is for "Pain assessment and sudoscan and test including cardio-respiratory ANS function and sleep study." The RFA is not provided in the medical file. Treatment history has included Physical therapy and medications. The patient is s/p ulnar nerve surgery on 09/02/14.

Per www.us.impeto-medical.com/sudoscan/about-sudoscan/ states: "The SUDOSCAN device is cleared for sale in the USA by the Food and Drug Administration. SUDOSCAN is a new test that provides an accurate evaluation of sweat gland function through galvanic skin response in less than 3 minutes. SUDOSCAN measures the ability of the sweat glands to release chloride ions in response to an electrochemical activation on the palm of the hands and soles of the feet, areas with the highest sweat gland density. It is a dynamic test equivalent to a stress test in cardiology [1]." ODG-TWC, Pain (Chronic) Chapter under Autonomic nervous system function testing states: "Not generally recommended as a diagnostic test for CRPS." ODG Guidelines, Pain (Chronic) chapter, regarding Polysomnography states: Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Criteria for Polysomnography: 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. According to progress, report 03/18/15, the patient presents with right shoulder and right wrist pain. Physical examination noted severe right shoulder pain and weakness, and positive impingement sign. Examination of the right wrist revealed tenderness, spasms and decreased ROM. The patient is s/p ulnar nerve surgery on 09/02/14 and right shoulder surgery in November of 2011. There is no discussion regarding this request and a RFA is not provided in the medical file. The UR denied the request stating "there is no rationale for a questionable request; no documentation of cardiorespiratory dysfunction or issues with sleep". In this case, none of the progress reports discusses cardiac or respiratory complaints by the patient that might show dysfunction of the autonomic nervous system and there is no documentation of excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, or personality change that would indicate a sleep study. No medical rationale was provided to establish the medical necessity of this request. Therefore, the requests ARE NOT medically necessary.