

Case Number:	CM14-0005664		
Date Assigned:	04/30/2014	Date of Injury:	09/02/2011
Decision Date:	07/08/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	01/13/2014

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 Occupational Medicine and is licensed to practice in California. 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 applicant has filed a claim for chronic shoulder, elbow, and wrist pain reportedly associated with an industrial injury of September 2, 2011. The applicant was described as exhibiting decreased sensorium about the thumb and index finger in C6 distribution. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; shoulder and elbow corticosteroid injection therapy; transfer of care to and from various providers in various specialties; and extensive periods of time off of work, on total temporary disability. In a progress report dated December 6, 2013, the claims administrator denied a request for 12 sessions of chiropractic manipulative therapy, and electrodiagnostic testing of the right upper extremity. The applicant's attorney subsequently appealed. In a handwritten doctor's first report (DFR) dated August 28, 2013 the applicants new primary treating provider (PTP) noted that the applicant report a persistent hand, shoulder, and neck pain with associated paresthesias. The applicant was given diagnosis of cervical strain, shoulder tendinopathy, hand and wrist strain, and elbow tendinopathy. Twelve sessions of chiropractic manipulative therapies were sought for the right shoulder. The applicant was placed off of work, on total temporary disability. Oral Orudis and Protonix were endorsed. A subsequent note of November 27, 2013 was notable for comments that the applicant report a persistent neck and shoulder pain with associated numbness, tingling, and paresthesias predominantly involving the left hand, it was stated. Right hand numbness was given as a diagnosis in a later section of report it was stated. The applicant exhibited limited right shoulder range of motion. Electrodiagnostic testing of the right upper extremity was sought to rule out "neuropathy" while the applicant was placed off of work, on total temporary disability. It was stated that the applicant should continue manipulative therapy and physical therapy as of that point in time. An earlier note of August 28, 2013 was notable for comments that the applicant had had electrodiagnostic testing of the right hand and arm but does

not recall the results of the study. In a medical legal evaluation of June 17, 2013, the applicant was given a 15% whole percent impairment rating for chronic shoulder pain, elbow pain, and right lateral epicondylitis. The applicant was described as having undergone electrodiagnostic testing of the right upper extremity on December 13, 2011, which is reportedly unremarkable.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC SESSIONS 2 TIMES A WEEK FOR 6 WEEKS FOR THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: The request for 12 sessions of chiropractic manipulative therapy is not medically necessary, medically appropriate, and indicated here. Page 58 of the MTUS Chronic Pain Medical Treatment Guidelines does not specifically address the topic of manipulative therapy for the shoulder; the issue is seemingly present here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, page 203, manipulation of bimanual therapist has been described as effective for applicants with frozen shoulders. The period of treatment, however, is limited to a few weeks, ACOEM notes, because of result of decreased with time. In this case, the six-session course of manipulative treatment, thus, runs counter to ACOEM principles and practices. It is further noted that the applicant was several years remote from the date of injury as of the date of the request for further manipulative treatment. Additionally, there was no evidence that the applicant in fact carry a diagnosis of frozen shoulder. The applicant was described on November 27, 2013 exhibiting relatively well-preserved right shoulder range of motion, flexion, and abduction in 140 and 150 degrees range. Manipulative therapy on the order of that proposed was not indicated, for all the stated reasons. Therefore, the request is not medically necessary.

EMG FOR THE RIGHT UPPER EXTREMITY: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 261.

Decision rationale: The proposed EMG of the right upper extremity, conversely, is medically necessary, medically appropriate, and indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, page 261, electrodiagnostic testing may be repeated later in the course of treatment if symptoms persist in applicants in whom initial testing was negative. In this case, the applicant apparently had earlier electrodiagnostic testing of the right upper extremity, which was apparently negative, in late 2011. Ongoing symptoms of upper extremity paresthesias and

dysesthesias seemingly persist. Electrodiagnostic testing to help establish the presence of possible carpal tunnel syndrome and/or cervical radiculopathy is indicated. Therefore, the request is medically necessary.

NCS OF RIGHT UPPER EXTREMITY: Overturned

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): 261.

Decision rationale: Similarly, the proposed nerve conduction testing of right upper extremity is likewise medically necessary, medically appropriate, and indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, page 261, electrodiagnostic testing may be repeated later in the course of treatment in the applicants in whom earlier testing was initially negative. In this case, the applicant in fact had negative electrodiagnostic testing in 2011. Symptoms of upper extremity paresthesias persist, calling into question of possible cervical radiculopathy versus carpal tunnel syndrome. Electrodiagnostic testing is clearly delineated the same is indicated. Therefore, the request is medically necessary.