

<b>Case Number:</b>	CM14-0008701		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	08/14/2009
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	12/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 patient is a 68-year-old male who has filed a claim for rotator cuff syndrome associated with an industrial injury date of August 14, 2009. Review of progress notes indicates neck pain radiating to the upper extremities, low back pain radiating to the lower extremities with numbness and weakness, left buttock pain radiating to the posterolateral aspect of the left thigh with numbness and weakness, numbness of the hands, and pain in the left shoulder. Findings include decreased cervical and left shoulder range of motion, positive Phalen's on the left, decreased right grip strength, tenderness and spasms of the lumbar musculature, positive sacroiliac pathology maneuvers, positive straight leg raise test bilaterally, decreased lower extremity motor strength (quadriceps, hamstrings, and gastrocnemius), and severe pain upon deep palpation of the L5-S1 spinous processes with pain radiating to corresponding dermatomes bilaterally. Electrodiagnostic study of the upper extremities dated August 30, 2013 showed C5 radiculopathy and moderate bilateral carpal tunnel syndrome, constituting a double crush syndrome. Treatment to date has included NSAIDs, opioids, muscle relaxants, physical therapy, chiropractic therapy, acupuncture, sacroiliac joint injection, surgeries to the left wrist, and trigger finger releases of the left index and middle fingers. There is note that this patient was recently approved for left shoulder surgery. Utilization review from December 30, 2013 denied the requests for chiropractic therapy to the left shoulder 2x4 as this patient has had extensive PT/chiropractic therapy and there was no documentation of objective improvement; post-op ultrasound of the left shoulder as it is not supported as a treatment modality; post-op ice cooling machine for the left shoulder as use of ice/cold packs will suffice for edema control; and IF unit for post-op surgery to the left shoulder as there are no quality evidence of effectiveness.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC THERAPY TO THE LEFT SHOULDER, TWO TIMES A WEEK FOR FOUR WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Manipulation.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. According to ODG, 9 visits over 8 weeks are recommended for sprains and strains of the shoulder. There is documentation that this patient had chiropractic therapy and physical therapy in the past. The derived benefits and functional improvement from these visits were not documented. Additional information is necessary at this time. Therefore, the request for chiropractic therapy to the left shoulder, two times a week for four weeks is not medically necessary.

**POST-OPERATIVE ULTRASOUND, LEFT SHOULDER:** 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 Ultrasound, Therapeutic Page(s): 123.

**Decision rationale:** According to CA MTUS Chronic Pain Medical Treatment Guidelines, therapeutic ultrasound is not recommended, as the effectiveness remains questionable. Additionally, it is noted that the patient was recently approved for left shoulder surgery. Therefore, the request for post-operative ultrasound for the left shoulder is not medically necessary.

**POST-OPERATIVE COOLING MACHINE, LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Cold compressoin therapy.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, cold compression therapy is not recommended in the shoulder, as there are no published studies. There is no indication as to why ice/cold packs cannot be used instead. Therefore, the request for post-operative cooling machine, left shoulder is not medically necessary.

**IF UNIT FOR POST-OPERATIVE SURGERY, LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** Page 118-120 of Chronic Pain Medical Treatment Guidelines state that a one-month trial of the IF unit may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications, when pain is ineffectively controlled with medications due to side effects, in patients with a history of substance abuse, in the presence of significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or if the condition is unresponsive to conservative measures. In this case, the patient has been recently approved for left shoulder surgery. However, the patient's post-operative course is not known, and thus this request is not necessary at this time. Therefore, the request for IF (Interferential) unit for post-operative surgery for left shoulder is not medically necessary.