

<b>Case Number:</b>	CM14-0010854		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	05/20/2012
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2014

### 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 Orthopedic Surgery and is licensed to practice in Maryland. 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 injured worker is a 53 year old male injured May 2012, has ongoing complaints of right shoulder pain with radiating pain throughout the right arm as well as the neck. The injured worker also reported numbness and a tingling sensation. The therapy note dated 09/14/13 indicates the injured worker having completed 15 physical therapy sessions to date. The clinical note dated 07/11/13 indicates the injured worker having completed 27 physical therapy sessions to date. The note indicates the injured worker doing overall well. However, the injured worker did have continued complaints of a dull and sharp pain at the lateral aspect of the right shoulder with radiation of pain into the neck and down into the arms. The injured worker rated the pain as 2/10. Upon exam, the injured worker demonstrated negative Hawkin's and Neer's signs. Minimal range of motion deficits were identified at the right shoulder to include 150 degrees of flexion, 160 degrees of abduction, 70 degrees of internal rotation, and 80 degrees of external rotation. No strength or reflex deficits were identified. The clinical note dated 12/20/13 indicates the initial injury occurred when he was picking up leaves with a coworker when he slipped on a plastic bag resulting in a fall on the right side. The clinical note dated 02/05/14 indicates the injured worker rating his right shoulder pain as 3/10. There is an indication the injured worker has shown progressive numbness and tingling. The injured worker has also previously undergone a surgical intervention. The note indicates the injured worker having undergone a right shoulder arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC TREATMENT WHICH INCLUDE SUPERVISED PHYSIOTHERAPY FOR THE RIGHT WRIST QTY: 18.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 11- FOREARM, WRIST & HAND COMPLAINTS, 265

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic manipulation Page(s): 58.

**Decision rationale:** The documentation indicates the injured worker having previously been approved for six chiropractic treatment sessions for the right wrist. Additional treatment would be indicated provided the injured worker meets specific criteria to include an objective functional improvement following a full course of treatment. No objective data was submitted confirming the injured worker's positive response to the previously rendered treatment. Therefore, it is unclear if the injured worker would respond to additional therapy at this time. Therefore, this request is not indicated as medically necessary based on Chronic Pain Medical Treatment Guidelines.

**ACUPUNCTURE THERAPY FOR THE RIGHT WRIST QTY: 12.00: Upheld**

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

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

**Decision rationale:** The documentation indicates the injured worker having an extensive right shoulder history. However, no information was submitted regarding the injured worker's medical need for treatment at the right wrist. No information was submitted regarding the injured worker's significant functional deficits likely to benefit from the use of acupuncture treatments. Therefore, this request is not indicated based on Acupuncture Medical Treatment Guidelines.

**COMPUTERIZED ROM (RANGE OF MOTION) AND MUSCLE STRENGTH TESTING QTY: 1.00: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** According to American College of Occupational and Environmental Medicine (ACOEM) guidelines, range of motion testing is part of a work-up in order to determine any functional deficits. Therefore, it does not appear that a separate treatment would be necessary. Range of motion testing may be indicated; however, it would be reasonable to undergo this testing in a typical office assessment. Recommend non certification.

**X-RAY RIGHT ELBOW: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES 2ND EDITION, 2004, CHAPTER 10- ELBOW COMPLAINTS, 238

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 587.

**Decision rationale:** According to American College of Occupational and Environmental Medicine (ACOEM) guidelines, x-rays of the elbow would be indicated provided the injured worker has demonstrated clinical findings consistent with osseus involvement. There is an indication the patient has findings consistent with medial epicondylitis. No information was submitted regarding the medical necessity for x-rays of the elbow. Therefore, this request is not indicated.

**RETROSPECTIVE: URINE DRUG SCREEN (DOS: 12/20/13): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN, , 43

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines, urine drug screens are indicated for injured workers who have been identified to be at risk for drug misuse or have previous studies confirming non-compliance with the prescribed drug regimen. No information was submitted regarding the injured worker's aberrant behavior, drug misuse or previous inconsistencies. Therefore, this request is not indicated.