

<b>Case Number:</b>	CM14-0157234		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	10/29/2012
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 49 year-old male who reported a work related injury on 10/29/2012 due to a fall. His diagnoses were noted to include right shoulder impingement, right shoulder pain, right shoulder sprain/strain, and rule out shoulder internal derangement. Past treatment included physical therapy, home exercise program, and occupational therapy. His Diagnostic studies were noted to include an X-ray of the right shoulder on 11/16/2014, which revealed negative fracture for dislocation, an MRI of the upper extremities on 11/16/2012 which revealed moderate to severe supraspinatus and infraspinatus tendinosis with superimposed moderate grade partial thickness, focal hypotense signal within the junction of the posterior supraspinatus and anterior spinatus tendons, and moderate acromioclavicular joint osteoarthritis. His surgical history included a right shoulder arthroscopy on 05/20/2013. Upon examination on 08/14/2014 the injured worker complained of intermittent, activity related, right shoulder pain with occasional stiffness/aches upon waking in the morning. Upon physical examination, it was noted that range of motion of the shoulder and elbow was within normal limits bilaterally. There was minimal tenderness to palpation of the right biceps tendon and subacromial space. The Neers and Hawkins test were noted to be negative. There was 5/5 muscle strength with resisted external rotation in adduction and abduction, the empty cans testing and internal rotation in shoulder adduction. There was no arm drop; horn blower's and external rotation lag signs present. The patient did exhibit a negative O'Brien's, Speed's, and Yergason's maneuver. There was no evidence of varus and valgus stress test at 30 degrees of elbow flexion. Additionally, there was no evidence of tenderness to palpation of the radial head, medial or lateral humeral epicondyles. The treatment plan consisted of ultrasound Therapy to the right elbow and shoulder and infrared therapy to the right Shoulder. The rationale for the request was not submitted for review. A request for authorization form was not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Ultrasound Therapy (Right Elbow): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Therapeutic ultrasound.

**Decision rationale:** The request for ultrasound therapy to the elbow is not medically necessary. The Official Disability Guidelines state, ultrasound therapy is recommended as a conservative option if there is evidence of objective functional improvement after trial use. Three trials compare ultrasound treatment to controls for epicondylitis. All three report a trend towards better outcomes with ultrasound. However, this difference reached statistical significance in only one. In regards to the injured worker, there is very little evidence in regards to complaints of the elbow. Additionally, there was no evidence of tenderness to palpation of the radial head, medial or lateral humeral epicondyle and range of motion was noted to be within normal limits. As such, the request is not medically necessary.

### **Ultrasound Therapy (Right Shoulder): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The request for ultrasound therapy to the right shoulder is not medically necessary. The Official Disability Guidelines state, ultrasound therapy is recommended for calcific tendonitis of the shoulder in the short term. But the evidence does not support use of ultrasound for other conditions of the shoulder. Both ultrasound and pulsed electromagnetic field therapy resulted in improvement compared to placebo in pain in calcific tendinitis. There is no evidence of the effect of ultrasound in generalized shoulder pain mixed diagnosis, adhesive capsulitis or rotator cuff tendinitis. When compared to exercises, ultrasound is of no additional benefit over and above exercise alone. As, the guideline to do not support the use of ultrasound therapy with any other condition other than calcific tendonitis of the shoulder. Therefore, the request for ultrasound therapy to the right shoulder is not medically necessary.

### **Infrared Therapy (Right Shoulder): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The request for infrared therapy to the right shoulder is not medically necessary. The Official Disability Guidelines state thermootherapy is under study. In regards to the injured worker, within the documentation there is no evidence presented that would warrant the need for specialized equipment for heat therapy. As such, the request for infrared therapy to the right shoulder is not medically necessary.