

<b>Case Number:</b>	CM14-0184088		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	05/25/2014
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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:

In a Utilization Review Report dated October 22, 2014, the claims administrator denied x-rays of the cervical spine and bilateral shoulders and conditionally denied 12 sessions of chiropractic manipulative therapy, approved a diagnostic study of the right shoulder, denied a home TENS unit, and denied a replacement sling. The claims administrator invoked non-MTUS ODG Guidelines to approve the shoulder ultrasound in favor of the MTUS-adopted ACOEM Guidelines in Chapter 9. The applicant's attorney subsequently appealed. On October 7, 2014, the applicant apparently transferred care to a new Primary Treating Provider (PTP). It was suggested that the applicant's employers had earlier told him to self-procure treatment as opposed to filing a worker's compensation claim. The applicant apparently obtained attorney representation and was directed to his current treating provider. 9/10 neck and bilateral shoulder pain were reported with multiple spasms and diffuse paraspinal and periscapular tenderness appreciated. Upper extremity sensorium and motor function were intact. Chiropractic manipulative therapy, shoulder ultrasound, home TENS unit, Ultram, and a replacement sling were endorsed while the applicant was placed off of work, on total temporary disability. The applicant exhibited significantly limited shoulder range of motion with flexion to 44 degrees about the right versus 76 degrees about the left, it was incidentally noted. Ultram was endorsed for pain relief purposes. The applicant was given diagnoses of cervical strain and bilateral shoulder strain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**An x-ray series of the cervical spine with two views and an x-ray series of the bilateral shoulders with two views:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 182, 207, Table 8-8. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic) / Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 182, 209, 214.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, page 214, the routine usage of radiographs for shoulder complaints is "not recommended" before four to six weeks of conservative treatment. Here, it was not clearly stated what was sought. It was not clearly stated what was suspected. It was not clearly stated why plain film imaging of the cervical spine was being sought. The applicant was given diagnoses of bilateral shoulder strain/nonspecific shoulder pain. The MTUS Guideline in ACOEM Chapter 9, Table 9-5, page 209, however, scores radiography/x-rays of the shoulder a "0/4" in their ability to identify and define regional pain involving the shoulder/nonspecific shoulder pain. Similarly, the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, page 182 note that the routine usage of cervical spine radiography if red flags are absent is "not recommended." In this case, there were, in fact, no red flag diagnoses, signs, or symptoms present, which would compel x-rays of the cervical spine and/or bilateral shoulders. The applicant was given diagnoses of nonspecific neck and shoulder pain/cervical and shoulder strains. There was no mention of any red flag diagnosis being suspected here, such as fracture, tumor, infection, dislocation, etc., which would be detectable via plain film imaging of cervical spine and/or bilateral shoulders. Therefore, the request is not medically necessary.

**A home TENS unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 203, 181.

**Decision rationale:** As noted in MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, page 181, TENS therapy, the modality at issue, is deemed "not recommended" in the management of the neck and upper back complaints, as are present here. Similarly, the MTUS Guideline in ACOEM Chapter 9, page 203, notes that TENS units are "not supported" by high quality medical studies for acute and sub-acute shoulder complaints, as were present here, on or around the date of the request. No rationale for selection of this particular modality in the face of the tepid-to-unfavorable ACOEM position on the same was proffered by the attending provider. There was no attempt made to furnish the TENS unit on a trial basis. There was mention of other first and second line modalities being trialed and/or failed before the TENS unit in question was considered. Therefore, the request is not medically necessary.

**A replacement sling for the right upper extremity/shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, page 213, the prolonged usage of a sling only for symptom controlled purposes is "not recommended." Here, the applicant has been given diagnoses of nonspecific shoulder pain/shoulder strain. These are not diagnoses for which prolonged usage of a sling would be indicated, per ACOEM. Therefore, the request is not medically necessary.