

<b>Case Number:</b>	CM14-0078557		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	01/24/2012
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2014

### 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 Chiropractic and is licensed to practice in Texas and Alabama. 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 59 year old female with a 1-24-12 recorded date of injury. The accident is described as one in which the patient's right foot got tangled in a computer wire causing her to fall forward onto her hands, arms, and knees. Complaints include: neck pain, right shoulder pain, right wrist pain, left knee pain, right knee pain, and left ankle pain. The records indicate the patient has received related treatment including: medications, injection, acupuncture, right knee surgery, chiropractic, physical therapy, and foot orthotics. There is a 3-19-14 chiropractic PR-2 is submitted. The record notes complaints including: neck pain, right shoulder pain, right wrist pain, left knee pain, right knee pain, left ankle pain, and right ankle pain. Examination includes: cervical spine range of motion, Shoulder/wrist/knee/neck/upper back palpation, knee range of motion, ankle range of motion findings. Treatment recommendation includes physical therapy 2x4 for the knees. A 4-16-14 chiropractic PR-2 is submitted. Examination includes cervical spine range of motion, shoulder range of motion, shoulder/wrist/knee/neck/upper back palpation, knee range of motion, ankle range of motion findings. Diagnosis is unchanged. The record notes 5 PT visits were provided to date. Treatment plan includes additional chiropractic 2x/wk x4wks and ANS function scan. A prior 4-26-14 review notes non-recommendation of the requested services. There is a 5-20-14 application for independent review related to the request for: shoulder manipulation; and infrared, e-stim, and ultrasound to the right shoulder and right knee 2x/wk x4wks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic adjustment for the right shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2014, shoulder .. Official Disability Guidelines,Chiropractic Guidelines Sprains and strains of shoulder and upper arm

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

**Decision rationale:** MTUS Guidelines does not address utilization of manipulation for shoulder conditions. ODG notes: In general, it would not be advisable to use this modality beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. The patient has reportedly been provided five chiropractic treatments as of 4-16-14 with no evidence of functional improvement. As such, medical necessity of the request for right shoulder adjustment is not supported with the application of evidence based guidelines. The request is not medically necessary.

**Infrared for the right shoulder and right knee: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2014, shoulder... Official Disability Guidelines Chiropractic Guidelines Sprains and strains of shoulder and upper arm

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** MTUS and ODG Guidelines do not make recommendation regarding utilization of infrared in the management of shoulder and knee conditions. ACOEM Guidelines do not apply. As such utilization of infrared for the right shoulder and knee is not supported with the application of evidence based guidelines. The request is not medically necessary.

**Electrical Stimulation for the right shoulder and right knee: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2014, shoulder... Official Disability Guidelines, Chiropractic Guidelines Sprains and strains of shoulder and upper arm

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

**Decision rationale:** MTUS Chronic Pain Medical Treatment guidelines indicates NMES/TENS is: Not recommended as a primary treatment modality, but a one-month home-based TENS trial

may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. There is no indication of an intended one-month home-based TENS trial to be used as an adjunct to a program of evidence-based functional restoration, for the conditions described in guidelines. As such medical necessity of the request for Electrical Stimulation for the right shoulder and right knee is not supported with the application of MTUS guidelines. The request is not medically necessary.

**Ultrasound for the right knee and right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 2014, shoulder... Official Disability Guidelines, Chiropractic Guidelines Sprains and strains of shoulder and upper arm

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

**Decision rationale:** MTUS guidelines does not address utilization of ultrasound in the management of knee and shoulder conditions. ODG Guidelines indicates ultrasound may be used for calcific tendinitis. There is no record of such diagnosis. Regarding utilization of ultrasound for knee conditions, ODG Guidelines notes it is: Not recommended over other, simpler heat therapies. As such medical necessity of utilization of ultrasound to the right knee and right shoulder is not supported with the application of evidence based guidelines. The request is not medically necessary.