

<b>Case Number:</b>	CM14-0200207		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	04/03/2014
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 61 year old male with a date of injury of 04/03/2013. He had cumulative trauma and on that day had a right knee strain/sprain. He had bilateral carpal tunnel release surgery about 12 to 15 years ago. He had left shoulder surgery 10 - 12 years ago. He had right knee surgery (meniscectomy and synovectomy) on 07/18/2013. On 11/05/2013 he was P&S; he was 5'8" tall and weighed 295 pounds. On 05/15/2014 he had left shoulder pain. He had full range of motion but the left shoulder strength was 3/5. X-ray revealed no fracture or dislocation and he was treated for tendonitis of the left shoulder. On 09/17/2014 he had bilateral shoulder x-rays that revealed degenerative changes. The same day knee x-rays revealed bilateral degenerative changes. He also had slight degenerative changes on lumbar x-ray. That day he had tenderness to palpation of the cervical spine. There was cervical paravertebral muscle spasm. Bilateral shoulder impingement signs were present.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment of unspecified body 2x6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and Manipulation Page(s): 58.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines, MTUS (Effective July 18, 2009) Page 58, Manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion.-Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks.Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.-Ankle & Foot: Not recommended.-Carpal tunnel syndrome: Not recommended.-Forearm, Wrist, & Hand: Not recommended.-Knee: Not recommended.The requested 12 visits was appropriately denied and modified to 6 visits over 2 weeks. For further treatment there must be objective documentation of functional improvement as noted above. Again, the requested 12 visits were not consistent with MTUS guidelines.

**Home interferential unit/moist heating pad:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287 - 316, 300.

**Decision rationale:** According to ACOEM Chapter 12 Low Back complaints, page 300 the requested home inferential unit is one of the passive treatment modalities that is not recommended. Page 300 notes, insufficient evidence exist to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as inferential therapy." Since the unit is not recommended, the pad is not medically necessary.