

<b>Case Number:</b>	CM15-0009340		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	01/04/2012
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 was a 31 year old male, who sustained a work related injury, January 4, 2014. Who sustained a right shoulder injury wit right index finger pain with worsening radiation up to the wrist, with numbness and tingling. The injured workers chief complaint was pain in the right shoulder and index finger. The injured worker was diagnosed with Status post right shoulder arthroscopic surgery for superior labrum anterior cuff lesion tear repair, right finger volar distal interphalangeal laceration with resultant sensory loss from the digit nerve as well as decreased range of motion of the distal interphalangeal joint, stress and insomnia. The injured worker was treated with topical creams, according to the progress note of December 22, 2014, off oral pain medications and postoperative physical therapy. On December 22, 2014, the primary treating physician requested authorization for computerized range of motion machine and muscle testing and chiropractic services for the right shoulder 3 times a week for 6 weeks for pain and muscle testing of the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Computerized Range of Motion and Muscle testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, and Hand/Computerized Muscle Testing

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Forearm, Wrist, and Hand Chapter, under Computerized muscle testing

**Decision rationale:** The patient presents with unrated mild to moderate right shoulder pain. Patient also complains of unrated and worsening right index finger pain which ascends towards the wrist and associated numbness/tingling sensation to the index finger. The patient's date of injury is 01/04/12. Patient is status post right shoulder arthroscopy with superior labrum repair at a date unspecified, has no documented surgical history directed at finger complaint. The request is for COMPUTERIZED RANGE OF MOTION AND MUSCLE TESTING. The RFA is dated 12/22/14. Physical examination dated 12/15/14 revealed a well healed surgical scar on the right shoulder, tenderness to palpation of the right deltoid muscle, weakness and reduced range of motion secondary to pain. Right wrist/hand examination revealed a well healed laceration scar from original injury, tenderness to palpation of the wrist joint, noted hypoesthesia on the right index finger pad. The patient is currently prescribed unspecified topical creams for finger pain. Diagnostic imaging was not included. Patient is temporarily totally disabled for 6 weeks as of 12/15/14 progress report. ODG Guidelines, Forearm, Wrist, and Hand Chapter, under Computerized muscle testing states: "Not recommended. There are no studies to support computerized strength testing of the extremities. The extremities have the advantage of comparison to the other side, and there is no useful application of such a potentially sensitive computerized test. Deficit definition is quite adequate with usual exercise equipment given the physiological reality of slight performance variation day to day due to a multitude of factors that always vary human performance. This would be an unneeded test."In regards to the request for computerized range of motion testing for an unspecified joint, treater has not provided a reason for the request and the test is not supported by guidelines for this patient's chief complaint. ODG and MTUS guidelines do not discuss such testing for shoulder complaints, and ODG guidelines for wrist and hand indicate that such testing is unnecessary for the extremities. It is also unclear whether such testing is to be performed for this patient's finger complaint or for shoulder complaint. Without a clearer identification of the joints to be tested, a lack of rationale to why such testing is needed, and the lack of support from guidelines pertinent to this patient's workplace injury, the medical necessity cannot be substantiated. The request IS NOT medically necessary.

**Chiropractic 3 times a week for 6 weeks 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, Chiropractic Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 40.

**Decision rationale:** The patient presents with unrated mild to moderate right shoulder pain. Patient also complains of unrated and worsening right index finger pain which ascends towards the wrist and associated numbness/tingling sensation to the index finger. The patient's date of injury is 01/04/12. Patient is status post right shoulder arthroscopy with superior labrum repair at a date unspecified, has no documented surgical history directed at finger complaint. The request is for **CHIROPRACTIC 3 TIMES A WEEK FOR 6 WEEKS FOR THE RIGHT SHOULDER**. The RFA is dated 12/22/14. Physical examination dated 12/15/14 revealed a well healed surgical scar on the right shoulder, tenderness to palpation of the right deltoid muscle, weakness and reduced range of motion secondary to pain. Right wrist/hand examination revealed a well healed laceration scar from original injury, tenderness to palpation of the wrist joint, noted hypoesthesia on the right index finger pad. The patient is currently prescribed unspecified topical creams for finger pain. Diagnostic imaging was not included. Patient is temporarily totally disabled for 6 weeks as of 12/15/14 progress report. MTUS Guidelines, page 40 states the following regarding Manual Therapy and Manipulation: "Recommended for chronic pain if caused by musculoskeletal conditions and manipulation is specifically recommended as an option for acute 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 function 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. Treatment Parameters from state guidelines: a. Time to produce objective functional gains: 3-5 treatments. b. Frequency: 1-5 supervised treatments per week the first 2 weeks, decreasing to 1-3 times per week for the next 6 weeks, then 1-2 times per week for the next 4 weeks, if necessary. c. Optimum duration: Treatment beyond 3-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session."In regards to the request for 18 sessions of chiropractic treatment for this patient's chronic shoulder pain, the treater has exceeded guideline recommendations. MTUS guidelines indicate that manual manipulation such as chiropractic therapy be initiated on a trial basis with an optimum duration of 3-6 visits initially, with additional visits if there is documented objective improvement. While there is no evidence in the records provided that this patient has had any chiropractic treatment to date, this request does not imply an intent to conduct a trial period or determine efficacy before additional therapy. Therefore, this request IS NOT medically necessary.