

<b>Case Number:</b>	CM15-0168663		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	11/11/2014
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 47 year old male who sustained an injury on 11-11-14 resulted when he was attempting to lift a fish that weighed over 400 pounds with a co-worker. While placing a hook in the fish's tail he attempted to swing it towards the co-worker when the hook suddenly slipped causing his right shoulder to jerk backwards. He felt immediate severe pain in his right shoulder radiating to his neck, and right sided upper back. Testing included X-rays and MRI right shoulder and on 2-5-15 he had right shoulder surgery followed by physical therapy (20 sessions). Diagnoses are cervical musculoligamentous sprain, strain with right upper extremity radiculitis; status post right shoulder arthroscopy (2-5-15); thoracic musculoligamentous strain, sprain. The examination on 7-21-15 report he has neck pain, right shoulder pain and right sided upper back pain. There is tenderness to palpation with muscle guarding present over the bilateral paraspinal musculature and trapezius muscles; range of motion cervical spine was measured; right shoulder reveals well healed scars with tenderness to palpation. Impingement test is positive; range of motion right shoulder flexion 142 degrees; extension 40 degrees; abduction 128 degrees; adduction 40 degrees; internal rotation 62 degrees and grade 4.5 muscle weakness of the right shoulder is present in all six planes of motion. Requested treatments included chiropractic x 8 to the cervical spine, right shoulder and thoracic spine. This is to increase activities of daily living, reduce work restrictions, reduce pain level and reduce medication use. Purchase an inferential unit to decrease muscle spasm and pain. Electromyogram and nerve conductions studies of the right upper extremity to rule out cervical radiculopathy due to complaints of frequent numbness and tingling to the right upper extremity. He is temporarily

totally disabled for 6 weeks. The utilization review dated 7-31-15 approves partial certification for 6 chiropractic sessions for cervical and thoracic spine and deny purchase of inferential unit. Deny electromyogram and nerve conductions studies of the right upper extremity.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Chiropractic x 8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

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

**Decision rationale:** According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. It is not recommended for the upper extremities. In this case, the chiropractor therapy was requested for the shoulder as well as the spine. Since part of therapy is not supported the request above is not medically necessary.

**Purchase of an IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 118-120.

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

**Decision rationale:** According to the guidelines an IF unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, there is no indication for indefinite use of an IF unit. There is no mention of adjunctive interventions or failure of TENS. The request to purchase an IF unit is not medically necessary.

**EMG/NCV of the right upper extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265,272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter and pg 38.

**Decision rationale:** According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. An EMG/NCV is recommended for ulnar impingement after failure of conservative treatment. It is not recommended for routine evaluation of nerve entrapment without symptoms. In this case, the cervical films have no abnormalities but exam findings do show weakness in the C5-C7 dermatomes and decreased sensation in the C5-C6 dermatomes. The request for the EMG/NCV is appropriate.