

<b>Case Number:</b>	CM15-0068571		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	11/26/2013
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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: North Carolina  
 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 55 year old female, who sustained an industrial injury on 11/26/2013. She reported an injury to her right upper extremity. Diagnoses have included right shoulder periscapular strain/tendinitis, right elbow/forearm strain with lateral epicondylitis and cubital tunnel syndrome and right wrist sprain. Treatment to date has included a soft cast and medication. According to the progress report dated 3/20/2015, the injured worker complained of right shoulder pain and right elbow/forearm pain. Exam of the right shoulder revealed tenderness to palpation. Exam of the right elbow/forearm revealed slight, diffuse swelling and tenderness to palpation. Authorization was requested for 12 chiropractic treatments for the right shoulder and a diagnostic ultrasound of the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Chiropractic treatments for the right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

**Decision rationale:** The California chronic pain medical guidelines section on manual manipulation states: 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. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 12 sessions. This does not meet criteria guidelines and thus is not medically necessary.

**1 Diagnostic ultrasound of the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

**Decision rationale:** The ACOEM chapter on shoulder complaints and imaging studies states: Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems). Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon). Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The provided clinical documentation for review does not meet the criteria per the ACOEM as outlined above for imaging studies and therefore the request is not medically necessary.