

Case Number:	CM13-0013545		
Date Assigned:	09/25/2013	Date of Injury:	12/06/2005
Decision Date:	01/16/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	08/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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.

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 60-year-old female who reported an injury on 12/06/2005 due to cumulative trauma. The patient underwent a functional restoration program with significant benefit. However, the patient continued to have persistent pain complaints of the shoulder and cervical spine. The patient underwent an electrodiagnostic study that did not reveal any abnormal findings. The patient's most recent clinical findings included a positive Tinel's test and a positive Phalen's test in the wrist and elbow and motor strength rated at 5/5. The patient's diagnoses included repetitive strain injury with myofascial pain syndrome, left shoulder rotator cuff injury with labrum tear status post arthroscopic labrum repair, possible peripheral neuropathy, cervical sprain/strain injury, and myofascial pain syndrome. The patient's treatment plan included acupuncture, myofascial release, and additional classes in a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 electro-acupuncture treatments: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested 8 electro-acupuncture treatments are not medically necessary or appropriate. The California Medical Treatment Utilization Guidelines recommend acupuncture be used when pain medication is reduced or not tolerated or as an adjunct therapy to

physical rehabilitation to hasten functional recovery. The clinical documentation submitted for review does not indicate that the patient is participating in an active therapy program that would benefit from the addition of acupuncture. Additionally, California Medical Treatment Utilization Schedule recommends a trial of 6 treatments as an appropriate time to produce functional improvement. The request exceeds this recommendation. There are no exceptional factors noted within the documentation submitted for review to provide support to extend treatment beyond guideline recommendations. As such, the requested 8 electro-acupuncture treatments are not medically necessary or appropriate.

1 infrared (unspecified frequency/duration): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested 1 infrared (unspecified frequency/duration) is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of passive modalities without patient participation in an active therapy program. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in any active therapy. Additionally, the request does not specify frequency or duration which does not allow timely reassessment to support the efficacy of this modality. As such, the requested 1 infrared (unspecified frequency/duration) is not medically necessary or appropriate.

1 myofascial release (unspecified frequency/duration): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (2009), Massage Therapy Page(s): 60.

Decision rationale: The requested myofascial release (unspecified frequency/duration) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of this type of therapy in conjunction with active therapy for a very short duration. The clinical documentation submitted for review does not indicate that the patient is participating in a home exercise program or any type of active therapy that would support the addition of this type of therapy. Additionally, the request does not include a specified frequency and duration. California Medical Treatment Utilization Schedule only recommends up to 4 to 6 visit for this type of therapy. As such, the requested 1 myofascial release (unspecified frequency/duration) is not medically necessary or appropriate.