

<b>Case Number:</b>	CM13-0043848		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	01/19/2013
<b>Decision Date:</b>	03/18/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Neurology, has a subspecialty in Neuromuscular Medicine 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. 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:

██████████ is a 57-year-old who sustained a work related injury on January 19 2013. She subsequently developed chronic neck, shoulder and wrist pain. According to a note dated on September 24 2013, the patient continued to have a chronic neck and shoulder pain. Her physical examination demonstrated tenderness in cervical paraspinal area with reduced range of motion, and tenderness in the wrist and shoulder. The provider request authorization to use the procedures mentioned below.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electro-acupuncture:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Physician Reviewer's decision rationale: According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for

a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Furthermore and according to the Acupuncture Medical Treatment Guidelines, Acupuncture with electrical stimulation is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. The Acupuncture Medical Treatment Guidelines goes on to state that, as a recommendation, the frequency and duration of acupuncture or acupuncture with electrical stimulation maybe performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months.(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). The request for electro-acupuncture is not medically necessary or appropriate

**Myofascial release:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Section Page(s): 61.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, this treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. There is a need for more information regarding the clinical status of the patient and previous treatment prescribed to the patient to determine the medical necessity of myofascial release. The request for myofascial release is not medically necessary or appropriate

**Infrared therapy, twice per week for six weeks, to the CS and right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Section Page(s): 58.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, infrared therapy is not recommended. There is no strong evidence to support its use for pain. The request for infrared therapy, twice per week for six weeks, to the CS and right shoulder is not medically necessary or appropriate