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| <b>Case Number:</b>   | CM13-0068728 |                              |            |
| <b>Date Assigned:</b> | 01/03/2014   | <b>Date of Injury:</b>       | 06/01/2011 |
| <b>Decision Date:</b> | 04/22/2014   | <b>UR Denial Date:</b>       | 11/26/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/19/2013 |

### 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. The expert reviewer is licensed in Chiropractic, and is licensed to practice in Texas. 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/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:

The patient is a 48-year-old female who reported an injury on 6/17/11. The mechanism of injury involved repetitive lifting. The patient is currently diagnosed with right shoulder tenosynovitis, cervicgia, cervical muscle spasm, cervical myalgia/myofasciitis, posttraumatic dizziness/vertigo, headaches, thoracalgia, thoracic muscle spasm, fibromyalgia, thoracic myalgia/myositis, right wrist and hand tenosynovitis, probable posttraumatic anxiety and depression, and probable posttraumatic insomnia. The patient was seen by [REDACTED] on 11/7/13. The patient reported persistent pain over multiple areas of the body. Physical examination revealed decreased cervical range of motion, decreased shoulder range of motion on the right, hypertonicity in the cervical region, tenderness of the right AC joint, crepitus, positive Neer's and Hawkins testing on the right, tenderness in bilateral wrists, hypertonicity in the thoracic region, and 4/5 deltoid strength on the left. Treatment recommendations included acupuncture with electrical stimulation, cupping, and infrared lamp therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INFRARED LAMP ACUPUNCTURE ONCE A WEEK FOR SIX WEEKS FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** The California MTUS/ACOEM guidelines state that physical modalities such as cutaneous laser treatment are not supported by high quality medical studies. Acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The Official Disability Guidelines state that acupuncture is recommended as an option for rotator cuff tendinitis, frozen shoulder, subacromial impingement syndrome, and rehab following surgery. Guidelines recommend an initial trial of 3-4 visits over two weeks. As per the documentation submitted, the patient's physical examination of the right shoulder revealed diminished range of motion, tenderness to palpation, crepitus, and positive Neer's and Hawkins testing. The patient does maintain a diagnosis of right shoulder tenosynovitis. However, the current request for six sessions of acupuncture treatment exceeds guideline recommendations. Additionally, the medical necessity for infrared lamp therapy in addition to the acupuncture treatment has not been established. Based on the clinical information received, the request is non-certified.

**CUPPING ACUPUNCTURE ONCE A WEEK FOR SIX WEEKS FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** The California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention. The Official Disability Guidelines state that acupuncture is recommended as an option for rotator cuff tendinitis, frozen shoulder, subacromial impingement syndrome, and following surgery. Guidelines recommend an initial trial of 3-4 visits over two weeks. The current request for six sessions of acupuncture therapy exceeds guideline recommendations. Additionally, the medical necessity for cupping therapy in addition to acupuncture treatment has not been established. Based on the clinical information received, the request is non-certified.