

Case Number:	CM13-0070479		
Date Assigned:	01/03/2014	Date of Injury:	05/15/2012
Decision Date:	08/11/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/24/2013

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 Board Certified in Physical Medicine & 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 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 56-year-old female who reported an injury on 05/15/2012 due to lifting a patient. On 09/13/2013 the injured worker reported intermittent slight to moderate left shoulder pain associated with stiffness, clicking, and popping. The pain increased to moderate with lifting, pushing and pulling, flexion, abduction, overhead work, and gripping motions, and was relieved by Motrin. A physical examination revealed range of motion of the left shoulder to be 120 degrees with forward flexion, 40 degrees with extension, 65 degrees with internal rotation, 25 degrees with external rotation, 135 degrees with abduction, and 40 degrees with adduction. Swelling was noted over the left elbow, wrist, and bilateral hands and finger along with deltoid muscle and rotator cuff muscle tenderness and a positive impingement test. Sensation was decreased diffusely over the left upper extremity. Motor strength of the left shoulder flexors was decreased to 4/5. The injured worker was status post left shoulder surgery performed on 01/05/2013. Her medications included Motrin for pain. It was noted that she was not receiving any physical therapy at the time. An MRI of the left shoulder dated 04/11/2013 showed supraspinatus tendinitis, infraspinatus tendinitis, small joint effusion, and subacromial/subdeltoid bursitis. Her diagnoses included left shoulder tendinitis and capsulitis and status post left shoulder arthroscopic surgery with residual decreased range of motion. The treatment plan was for 8 sessions of acupuncture to the left shoulder, continued use of Interferential (IF) 4 unit for the left shoulder (per week), and continued infrared to the left shoulder. The Request for Authorization form and rationale for treatment were not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE SESSIONS TO THE LEFT SHOULDER, QUANTITY 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS Acupuncture Treatment Guidelines state that frequency and duration of acupuncture with electrical stimulation may be performed with a time to produce effect of 3 to 6 treatments, a frequency of 1 to 3 times per week, and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented as defined. The rationale for acupuncture treatment versus physical therapy is unclear as there is nothing indicating that the injured worker can not participate in physical therapy. The request for 8 treatments would exceed the guideline recommendations, and without documented functional improvement with the 3 to 6 treatments recommended, additional treatments cannot be warranted. The request is not supported by the guideline recommendations as it exceeds the recommendation and the rationale provided is unclear. Given the above, the request is not medically necessary.

CONTINUE USE OF IF4 UNIT FOR THE LEFT SHOULDER (PER WEEK): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Level Laser Therapy Page(s): 57.

Decision rationale: The MTUS Guidelines state that low level laser therapy (LLLT) is not recommended. Despite some positive findings, data is lacking on how LLLT effectiveness is affected by 4 important factors; wavelength, treatment duration, dosage, and site of application over nerves instead of joints. Its effectiveness is still controversial. Based on the clinical information submitted for review, it appears that the injured worker has been using the IF4 unit; however, efficacy of this treatment option was not provided for review. Without documentation of objective functional improvement as a result of the IF4 unit, the request cannot be warranted. The request is not supported by the guideline recommendations, as low level laser therapy is not recommended and there is no documentation of efficacy with the prior use. Given the above, the request is not medically necessary.

CONTINUED INFRARED TO THE LEFT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Level Laser Therapy Page(s): 57.

Decision rationale: The MTUS Guidelines state that low level laser therapy is not recommended as there is insufficient data to draw firm conclusions about the effectiveness of low level laser therapy compared to other treatments. The request for continued infrared therapy implies that the injured worker had been using infrared therapy to the left shoulder. However, there was no documented objective functional improvement as a result of the previous therapy. Without evidence of efficacy with treatment, continuation would not be supported. The request is not supported by the guideline recommendations as low level laser therapy is not recommended and there is no documentation regarding efficacy with the prior use. As such, the request is not medically necessary.