

<b>Case Number:</b>	CM14-0018462		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	02/11/2009
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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, has a subspecialty in Interventional Spine 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 60 year old with an injury date on 2/11/09. Based on the 1/8/14 progress report provided by [REDACTED] the diagnoses are: 1. Repetitive strain injury; 2. Myofascial pain syndrome; 3. Wrist tendinitis; 4. Left carpal tunnel syndrome; 5. Status post left carpal tunnel release surgery in April 2012. Exam on 1/8/14 showed "local tenderness in bilateral wrist, elbow, and forearm. Well-healed surgical scar on right wrist, local tenderness in forearm and wrist area. Positive Tinel's and Phalen's test in left wrist." [REDACTED] is requesting infrared (bilateral wrists) and myofascial release (bilateral wrists). The utilization review determination being challenged is dated 1/16/14. [REDACTED] is the requesting provider, and he provided treatment reports from 2/25/13 to 1/8/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INFRARED (BILATERAL WRISTS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines LOW-LEVEL LASER THERAPY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG low back chapter online for: Infrared therapy (IR) Not recommended over other heat therapies. Where deep heating is desirable, providers may

consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). The IR therapy unit used in this trial was demonstrated to be effective in reducing chronic low back pain, and no adverse effects were observed; the IR group experienced a 50% pain reduction over 7 weeks, compared with 15% in the sham group. (Gale, 2006) See also Heat therapy.

**Decision rationale:** This patient presents with bilateral wrist and hand pain, worsened with physical activities. The physician has asked infrared (bilateral wrists) on 1/8/14. Patient has responded positively to electro-acupuncture treatment, improving patient's daily functioning on 1/8/14. Electro-acupuncture treatment on 12/17/13 involved use of infrared therapy, which is not recommended by ODG over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). In this case, the physician has asked for infrared (bilateral wrists) of an unspecified duration. ODG recommends a limited trial of IR therapy, but requested infrared treatment does not indicate a duration or timeframe. Recommendation is for denial.

**MYOFASCIAL RELEASE (BILATERAL WRISTS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 141.

**Decision rationale:** This patient presents with bilateral wrist and hand pain, worsened with physical activities. The physician has asked myofascial release (bilateral wrists) on 1/8/14. Patient has responded positively to electro-acupuncture treatment, improving patient's daily functioning on 1/8/14. Electro-acupuncture treatment on 12/17/13 involved use of myofascial release, which is not recommended for the treatment of acute, subacute, or chronic LBP or radicular pain syndromes per ACOEM. In this case, the physician has asked for myofascial release (bilateral wrists) which ACOEM guidelines do not recommend for patient's chronic back pain. Recommendation is for denial.