

<b>Case Number:</b>	CM14-0019674		
<b>Date Assigned:</b>	04/28/2014	<b>Date of Injury:</b>	05/15/2013
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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 Occupational 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 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:

Medical records from 2013 to 2014 were reviewed and showed pain in multiple areas. The primary locations of pain are in the neck, right shoulder, left elbow and right knee with pain level ranging 3-8/10. There is also sporadic swelling of the left elbow, right wrist soreness with extremes of motion and right knee instability. Physical examination showed tenderness over the right dorsal wrist, positive Tinel's in the cubital tunnel, and mild subluxation of the ulnar nerve. Other physical examination findings include tenderness over the cervical spine area with guarding and pain at the end of normal AROM in all directions; slight tenderness over the biceps and rotator cuff region of the right shoulder and over the 3x4cm cystic swelling just distal to the olecranon of the left elbow; point tenderness confined to the right wrist dorsum at the mid carpus; slightly decreased grip strength of the right hand; slight medial and posterior laxity of the right knee to valgus stress. The diagnosis were cervicgia due to cervical spine strain; right shoulder pain secondary to rotator cuff and biceps tendon strain; left elbow traumatic cyst with recurrent swelling; right wrist pain secondary to enthesopathy possible traumatic arthritis associated with loss of grip strength; right knee PCL partial tear and MCL grade 3 strain associated with loss of distal thigh muscle mass; and distal left fibular closed fracture, resolved. Utilization review dated January 23, 2014 denied the requests for electrical stimulation because the specific type of electrical stimulation requested has not been described; and myofascial release because it is not proven efficacious for the treatment of acute, subacute, or chronic low back pain and radicular pain syndromes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ELECTRICAL STIMULATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**Decision rationale:** As noted on page 114 of the CA MTUS Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy includes TENS, interferential current stimulation, microcurrent electrical stimulation, neuromuscular electrical stimulation, RS-4i sequential stimulator, electroceutical therapy, and sympathetic therapy. In this case, there is no documentation of failure of medications and conservative management strategies that would necessitate an electrical stimulation unit. Also, the specific modalities included in this request were not indicated. Therefore, the request for electrical stimulation is not medically necessary.

**MYOFASCIAL RELEASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** As stated on page 60 of the California MTUS Chronic Pain Medical Treatment Guidelines, massage therapy is recommended as an option and as an adjunct to other recommended treatment such as exercise, and should be limited to no more than 4-6 visits. In this case, the patient had physical therapy visits and it is unclear whether the patient has had prior myofascial release. Outcomes concerning previous treatment were not discussed. Moreover, the request does not indicate a specific body part to be treated. It is also unclear as to why a myofascial release was being requested. The medical necessity has not been established. Therefore, the request for myofascial release therapy is not medically necessary.