

Case Number:	CM14-0037470		
Date Assigned:	06/25/2014	Date of Injury:	07/14/2012
Decision Date:	08/05/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	03/28/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 injured worker is a 52-year-old female who was reportedly injured on July 14, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated March 5, 2014, indicated that there were ongoing complaints of pain and swelling in the right hand and wrist, as well as right shoulder pain and cervical spine pain. The physical examination demonstrated tenderness of the cervical spine along the bilateral paraspinal muscles with spasms present from C3 to C7. Examination of the right shoulder noted tenderness and spasms of the rotator cuff as well as a positive Speed's test and supraspinatus test. There was a trigger finger noted at the right thumb as well as tenderness to the right wrist and thumb. There was a positive Tinel's test and Finkelstein's test on the right side. Current treatment plan included electrical acupuncture, topical medications, psychosocial screening, an internal medicine consultation, a 3D magnetic resonance imaging of the cervical spine, a functional capacity evaluation and the use of an inferential stimulator. Previous treatment included 48 visits of prior physical therapy and 10 work hardening sessions. A request had been made for electro acupuncture to the right hand and right shoulder, manual acupuncture to the right hand and right shoulder, myofascial release and electrical stimulation and was not certified in the pre-authorization process on March 20, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electro Acupuncture, Manual Acupuncture to the right hand and right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to the American College of Occupational and Environmental Medicine, acupuncture procedures are generally not recommended for the shoulder region. Additionally, acupuncture procedures are recommended when pain medication is reduced or not tolerated. There was no documentation in the attached medical record that the injured employee was not tolerating or has reduced current medications. For these reasons, this request for electro and manual acupuncture for the right hand and right shoulder is not medically necessary.

Myofascial release: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: According to the medical record, the injured employee has previously had 48 visits of prior physical therapy and 10 work hardening sessions. There is no mention of the efficacy of these prior treatments or anything to suggest their failure that would necessitate considering other treatments such as myofascial release. Furthermore, the injured employee has complaints of right hand and wrist, right shoulder, and cervical spine issues and it was not specified where myofascial release is to be employed. For these reasons, this request for myofascial release is not medically necessary.

Electrical Stimulation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines, the use of an inferential stimulation unit is only recommended when a patient's pain is ineffectively controlled due to diminished effectiveness of medications or due to medication side effects. It is also recommended if there is limited ability to perform exercise/therapy or if previous treatments have been found to be ineffective. There was no documentation in the medical record that the injured employee has any of these issues. Therefore, this request for electrical stimulation is not medically necessary.

Infrared and Diathermy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: [http://www.merckmanuals.com/home/fundamentals/rehabilitation/treat-ment of pain and inflammation.html](http://www.merckmanuals.com/home/fundamentals/rehabilitation/treat-ment%20of%20pain%20and%20inflammation.html).

Decision rationale: As with the request for electrical stimulation, there was no documentation in the medical record that the injured employee had any previous problems to include ineffectively controlled pain due to diminished effectiveness of medications or due to medication side effects. Nor was it stated that there was limited ability to perform exercise/therapy or that previous treatments have been found to be ineffective. Therefore, it is unclear why there is a request for an additional therapy/treatment. This request for infrared and diathermy treatments is not medically necessary.