

<b>Case Number:</b>	CM14-0047987		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	10/18/2013
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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:

The patient is a 44-year-old male who has submitted a claim for Right Shoulder Rotator Cuff Injury, History of Right Shoulder Dislocation, Right Shoulder Tendonitis, Right Shoulder Sprain/Strain Injury, and Right Shoulder Rotator Cuff Tendonitis associated with an industrial injury date of October 18, 2013. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of right shoulder pain. On the physical examination, there was decreased right shoulder range of motion. Rotator cuff impingement test was positive. Deep tendon reflexes were normal and equal on both upper extremities. No sensory deficits were noted. Treatment to date has included medications, right shoulder arthroscopy, home exercises, physical therapy, right shoulder injection, and an unknown number of electroacupuncture and infrared therapy sessions. Utilization review from March 28, 2014 denied the request for Electroacupuncture times 12 visits - right shoulder because there was no documentation of specific functional improvements with previous acupuncture therapy; Infrared-right shoulder unknown number of treatments because there was no significant objective and functional gains from prior treatment; and myofascial release-right shoulder unknown number of treatments because there is lack of evidence of sustained benefit with this treatment and there are limited clinical deficits on examination.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electroacupuncture times 12 visits - right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the Acupuncture Medical Treatment Guidelines referenced by CA MTUS, acupuncture may be used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines allow the use of acupuncture for a frequency and duration of treatment as follows: time to produce functional improvement 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. Additionally, acupuncture treatments may be extended if functional improvement is documented. In this case, the patient previously underwent an unknown number of electro-acupuncture sessions. Furthermore, there was no documentation of objective evidence of functional gains with electro-acupuncture. There is no clear indication for continued electro-acupuncture therapy without evidence of functional improvement therefore, the request for Electroacupuncture time's 12 visits - right shoulder is not medically necessary.

**Infrared-right shoulder unknown number of treatments:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Procedure Summary last updated 03/18/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared Therapy.

**Decision rationale:** The CA MTUS does not specifically address infrared therapy (IR). Per the Strength of Evidence, hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. ODG states that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, the patient previously underwent IR therapy but the duration of therapy is unknown. Furthermore, the records did not clearly reflect continued functional benefits with IR therapy. There is no clear indication for continued use of IR therapy therefore, the request for Infrared-right shoulder unknown number of treatments is not medically necessary.

**myofascial release-right shoulder unknown number of treatments:** Upheld

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

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

**Decision rationale:** According to page 60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, massage therapy is recommended as an option. This treatment should be an adjunct to other recommended treatment, and it should be limited to 4-6 visits in most cases. In this case, the records showed that the patient was performing home exercises, which is a recommended treatment option; hence, massage therapy can be used as an adjunct. However, the present written request failed to specify the frequency and duration of intended treatment. Although massage therapy may be appropriate, the present written request is incomplete. Therefore, the request for myofascial release-right shoulder unknown number of treatments is not medically necessary.