

<b>Case Number:</b>	CM14-0094955		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/20/2013
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 licensed in Chiropractic 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 injured worker is a 51 year old male who reported low back, neck, left leg and bilateral shoulder pain from injury sustained on November 20, 2013. X-rays of the cervical spine revealed straightening of the lordotic curvature, otherwise normal. X-rays of the lumbar spine revealed minimal degenerative facet changes at L5-S1. Patient is diagnosed with cervical musculoligamentous sprain/strain; lumbar musculoligamentous sprain/strain with minimal facet arthrosis; bilateral shoulder strain and left hamstring muscle strain. Per medical notes dated May 22, 2014, patient complains of neck, low back and shoulder pain. Palpation of the cervical spine revealed mild paraspinal muscle soreness and guarding, left more than right; mild paraspinal muscle tenderness and guarding in the lumbar spine and tenderness over the posterior scapular muscles. Examination revealed decreased range of motion. Provider is requesting initial trial of 6 acupuncture treatments with infrared which was modified to 6 acupuncture treatments.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 Acupuncture Sessions C/Spine w/ Infra lamp:** 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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical Spine and Low back, Infrared Heat.

**Decision rationale:** Per the California MTUS Guideline, Acupuncture is used as an option when pain medication is reduced and not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce function improvement: 3-6 treatments. 2) Frequency: 1-3 times per week. 3) Optimum duration: 1-2 months. Acupuncture treatments may be extended if functional improvement is documented. Patient has not had prior Acupuncture treatment. The provider is requesting acupuncture for cervical spine with infrared X6 which was modified to Acupuncture X6. MTUS does not provide guidelines for Infrared heat therapy. Per ODG guidelines for low back - 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. ODG guidelines do not document infrared heat therapy for cervical spine. Per guidelines and review of evidence, 6 Acupuncture visits with infrared heat therapy are not medically necessary.

**Unknown Kinesio Tape:** 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 Official Disability Guidelines (ODG), Shoulder, Cervical Spine, Kinesiotaping.

**Decision rationale:** Per the ODG guidelines, utilization of Kinesiotaping (KT) for decreasing pain intensity or disability for patients with suspected shoulder tendonitis/impingement is not supported. (Thelen, 2008) Tape is commonly used as an adjunct for treatment and prevention of musculoskeletal injuries. A majority of tape applications that are reported in the literature involve nonstretch tape. The KT method has gained significant popularity in recent years, but there is a paucity of evidence on its use. The suppliers make claims of neuromuscular re-education. Per ODG guidelines- cervical spine under study: Patients with acute WAD receiving an application of Kinesio taping applied with proper tension, exhibited statistically significant improvements immediately following application and at a 24-hour follow-up. However, the improvements in pain and cervical range of motion were small and may not be clinically meaningful. The provider did not specify the body part in which the tape would be utilized, according to ODG guidelines for neck and shoulder Kinesio tape is not recommended. Per guidelines and review of records Kinesio tape is not medically necessary.