

Case Number:	CM14-0198437		
Date Assigned:	12/08/2014	Date of Injury:	12/07/2009
Decision Date:	01/27/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/25/2014

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 Acupuncture and 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 64 year old male who reported right shoulder pain from injury sustained on 12/07/09. Mechanism of injury was not documented in the provided medical records. There were no diagnostic imaging reports. Patient is diagnosed with right shoulder rotator cuff injury; internal derangement of the right shoulder and myofascial pain syndrome. Patient has been treated with rotator cuff surgery; status post carpal tunnel release; physical therapy; medication and acupuncture. According to utilization review, medical notes dated 11/07/14 revealed patient still complains of a lot of pain and discomfort involving the right shoulder and upper extremity. There is increase pain with cold weather. Examination of the right shoulder revealed there is decreased range of motion. Provider requested additional 2X6 acupuncture treatments/ myofascial and infrared which were modified to 2X3 acupuncture treatments by the utilization review on 11/18/14. There is no documentation afforded for review that establishes a clear, updated clinical status of the patient with current objective finding, functional deficits and the benefits obtained with acupuncture already approved/rendered that would substantiate a medical indication for additional care. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electro Acupuncture, infrared, myofascial release 2 times a week x 6 weeks for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per MTUS- Section 9792.24.1 Acupuncture Medical treatment Guidelines page 8-9: "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 had prior acupuncture treatment. Provider requested additional 2x6 acupuncture treatments/ myofascial and infrared which were modified to 2x3 acupuncture treatments by the utilization review on 11/18/14. There is no documentation afforded for review that establishes a clear, updated clinical status of the patient with current objective finding, functional deficits and the benefits obtained with acupuncture already approved/rendered that would substantiate a medical indication for additional care. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Additional visits may be rendered if the patient has documented objective functional improvement. Per MTUS guidelines, Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam or decrease in medication intake. Additionally requested visits exceed the quantity supported by cited guidelines. California MTUS Chronic Pain treatment guidelines do not address infrared therapy and other national guidelines such as ODG do not recommend infrared. The treating physician has not offered an evidence-based medical justification that supports this treatment request. Per review of evidence and guidelines, 2x6 electro-acupuncture treatments/ myofascial release and infrared are not medically necessary.