

<b>Case Number:</b>	CM15-0020813		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	04/14/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 42-year-old male who reported an injury on 04/14/2014. The mechanism of injury was unspecified. His diagnoses include cervical sprain, right shoulder sprain/strain with impingement, and thoracic sprain/strain. His past treatments included physical therapy, medications, and chiropractic care. On 08/15/2014, the injured worker complained of difficulty sleeping with decreased range of motion. The physical examination revealed tenderness to the thoracic paraspinals and trapezius. The physical examination of the right shoulder revealed tenderness to palpation with crepitus and impingement. The treatment plan included acupuncture with infra lamp, kinesio tape, IF unit, and a home shoulder exercise kit. A rationale was not provided. A Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture with infra lamp QTY: 6.00:** Upheld

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

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

**Decision rationale:** The request for acupuncture with infra lamp QTY: 6.00 is not medically necessary. According to the California MTUS Acupuncture Guidelines, acupuncture with electrical stimulation is used to decrease physiological effects for the release of endorphins to improve pain relief, reduction of inflammation, increase blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. The injured worker was indicated to have thoracic spine and right shoulder pain. However, there was lack of documentation in regards to a clear rationale for electrical stimulation acupuncture for the reduction of inflammation, to increase blood flow and circulation, analgesia through interruption of pain stimulus, and increase muscle relaxation. There was also a lack of documentation to indicate the injured worker had muscle spasms, inflammation, or scar tissue pain for the use acupuncture with electrical stimulation. Based on the above, the request is not supported by the evidence based guidelines. As such, the request for acupuncture with electrical stimulation is not medically necessary.

**Kinesio tape QTY: 1.00:** 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) - Treatment in Workers' Compensation (TWC), Treatment Integrated Treatment / Disability Duration Guidelines, Shoulders Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Kinesio tape.

**Decision rationale:** The request for Kinesio tape QTY: 1.00 is not medically necessary. According to the Official Disability Guidelines, Kinesio tape is not recommended. However, it is commonly used as an adjunct for treatment and prevention of musculoskeletal injuries. The injured worker was indicated to have been prescribed Kinesio tape. However, there was lack of documentation to indicate the use of the Kinesio tape in adjunct for treatment prevention of musculoskeletal injuries. Furthermore, the guidelines do not support or recommend the use of Kinesio tape. As such, the request is not supported by the evidence-based guidelines. As such, the request is not medically necessary.

**IF unit QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 07/18/2009 Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117-118.

**Decision rationale:** The request for IF unit QTY: 1.00 is not medically necessary. According to the California MTUS Guidelines, interferential current stimulation units are not recommended as an isolated intervention; however, a trial may be allotted if used in conjunction with recommended conservative treatments. The criteria for the use of an interferential stimulation unit includes pain that is ineffectively controlled due to diminished effectiveness of medications

or side effects; a history of substance abuse; significant pain from postoperative conditions limiting ability to perform intensive conservative treatments; and unresponsiveness to conservative measures, such as heat, or ice. The injured worker was indicated to have been prescribed an interferential unit. However, there was a lack of documentation the unit would be used as an adjunct to conservative therapy. There was also a lack of documentation to indicate the injured worker's pain was not effectively controlled due to diminished effectiveness of medications or side effects. There was also lack of documentation the injured worker had a history of substance abuse or had significant pain postoperatively that limited his ability to perform intensive conservative therapy. Furthermore, there was lack of documentation to indicate the injured worker was unresponsive to conservative measures. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Home shoulder exercise kit QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The request for Home shoulder exercise kit QTY: 1.00 is not medically necessary. According to the California MTUS/ACOEM Guidelines, instruction in home exercise is allotted for cases of unstable fractures, acute dislocations, instability, or hypomobility. Injured workers can also be advised of instructed passive range of motion exercises at home. The injured worker was indicated to have been prescribed a home shoulder exercise kit. However, there was lack of documentation to indicate the medical necessity of a home exercise kit due to unstable fractures, acute dislocations, instability, or hypermobility. As such, the request is not supported by the evidence based guidelines. Therefore, the request is not medically necessary.