

<b>Case Number:</b>	CM15-0024672		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	06/13/2013
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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 59-year-old female who reported an injury on 06/13/2013. The mechanism of injury was due to a slip and fall. Her diagnoses include thoracic spine myofascial pain syndrome secondary to right scapular dyskinesia, right shoulder impingement syndrome and right elbow lateral epicondyle secondary to overuse. Her past treatments include medications, surgery, and physical therapy. On 01/05/2015, the injured worker complained of upper back pain, right shoulder pain, and right elbow pain. The physical examination revealed tenderness to palpation of the bilateral upper/middle/lower thoracic region right greater than left with spasms and trigger point in the right upper/middle/lower thoracic region. There was also tenderness to palpation to the right shoulder anteriorly, posteriorly, laterally; and at the biceps tendon grooves, deltoid muscles, rotator cuff muscles, and AC joint. The injured worker was noted to have decreased range of motion in the shoulder; a positive Neer's; a positive Codman's, and positive supraspinatus test. The injured worker was also noted to have decreased motor strength and diffuse increased sensation to the right arm/shoulder. The treatment plan included a prescription for tramadol, compound cream, interferential unit, physical therapy, and a functional capacity examination to ensure the injured worker can safely meet the physical demands of their occupation. A Request for Authorization was received on 01/05/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** According to the California MTUS Guidelines, interferential current stimulation units are not recommended as an isolated intervention; however, may be used in adjunct to recommended treatment, such as returning to work, exercise, and medications. The criteria for an interferential stimulation unit include documentation that pain is ineffectively controlled due to diminished effectiveness of the medications or its side effects, history of substance abuse; significant pain from postoperative conditions limiting the ability to perform exercise programs or physical therapy treatments; and an unresponsiveness to conservative measures. The injured worker was noted to have chronic spine pain with spasm and trigger points. However, there was a lack of documentation indicating the injured worker's pain was ineffectively controlled due to diminished effectiveness of the medications or its side effects; had a history of substance abuse; documentation identifying significant pain for postoperative conditions that limits their ability to perform exercise programs or physical therapy treatments, and documentation of unresponsiveness to conservative measures such as repositioning, heat, or ice. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Acupuncture Evaluation and Treatment Thoracic Spine & Right Shoulder 2x Week For 6 Weeks:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines recommend a time to produce functional improvement of three to six treatments. The guidelines recommend a frequency of one to three times per week and a duration of one to two months. The injured worker was indicated to have an initial 6 sessions of acupuncture. However, there was a lack of documentation in regard to the assessment, to include objective functional improvement; and lack of acupuncture being used in adjunct to physical rehabilitation. There was also a lack of documentation in regards to documentation of analgesic response or reduction of medication use from the use of acupuncture. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

