Case Number:	CM15-0027068		
Date Assigned:	02/19/2015	**Date of Injury:**	06/05/2014
Decision Date:	04/14/2015	**UR Denial Date:**	02/04/2015
Priority:	Standard	**Application Received:**	02/12/2015

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: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 female, who sustained an industrial injury on 06/05/2014. She has reported right shoulder pain. The diagnoses have included right shoulder strain; adhesive capsulitis of the right shoulder; and right shoulder anterior superior aspect glenoid labrum tear. Treatment to date has included medications, physical therapy, and chiropractic sessions. Medications have included Diclofenac. Currently, the injured worker complains of right shoulder pain and stiffness, and improved function with physical therapy. A progress report from the treating physician, dated 01/19/2015, documented the injured worker to have improved right shoulder range of motion, and 4/5 muscle strength associated with motions. The treatment plan has included the request for continued physical therapy. On 02/04/2015 Utilization Review noncertified a prescription for Biofeedback training, 2 times weekly, unspecified shoulder; a prescription for Infrared, 2 times weekly, unspecified shoulder; a prescription for Ultrasound, 2 times weekly, unspecified shoulder; and a prescription for Supplies and materials, unspecified shoulder. The CA MTUS and the ODG were cited. On 02/12/2015, the injured worker submitted an application for IMR for review of a prescription for Biofeedback training, 2 times weekly, unspecified shoulder; a prescription for Infrared, 2 times weekly, unspecified shoulder; a prescription for Ultrasound, 2 times weekly, unspecified shoulder; and a prescription for Supplies and materials, unspecified shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofeedback training, 2 times weekly, unspecified shoulder: Upheld
Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24-25.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Biofeedback http://www.odg-twc.com/index.html.

Decision rationale: Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic low back pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. There is conflicting evidence on the effectiveness of biofeedback for treating patients with chronic low back problems. See the Pain Chapter for more information and references, as well as ODG biofeedback therapy guidelines. (Van Tulder, 1997) (Bigos, 1999). There is no documentation that the patient is a candidate for CBT program. Although the patient reported some pain improvement with physical therapy, there is no documentation of objective pain and functional improvement. Therefore, the request for Biofeedback training, 2 times weekly, unspecified shoulder is not medically necessary.

Infrared, 2 times weekly, unspecified shoulder: 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 Chapter, IR.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Infrared therapy (IR) http://www.odg-twc.com/index.html.

Decision rationale: According to ODG guidelines, Infrared therapy (IR), 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, (Gale, 2006) See also Heat therapy. There is no documentation of the outcome of previous physical therapy. ODG guidelines do not recommend infrared therapy for shoulder pain. Therefore, the request for Infrared, 2 times weekly, unspecified shoulder is not medically necessary.

Ultrasound, 2 times weekly, unspecified shoulder: 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 Ultrasound, therapeutic http://www.odg-twc.com/index.html.

Decision rationale: According to ODG guidelines, Ultrasound, therapeutic, recommended as indicated below. The evidence on therapeutic ultrasound for shoulder problems is mixed, (Philadelphia, 2001). Ultrasound provided clinically important pain relief relative to controls for patients with calcific tendonitis of the shoulder in the short term, (Ebenbichler-NEJM, 1999). However, the evidence does not support use of ultrasound for other conditions of the shoulder, (van der Heijden, 1999) (van der Windt, 1999) (Kurtais, 2004). Both ultrasound and pulsed electromagnetic field therapy resulted in improvement compared to placebo in pain in calcific tendinitis. There is no evidence of the effect of ultrasound in generalized shoulder pain (mixed diagnosis), adhesive capsulitis or rotator cuff tendinitis. When compared to exercises, ultrasound is of no additional benefit over and above exercise alone, (Green-Cochrane, 2003) (Michener, 2004). The results of this trial suggest that acupuncture is more efficacious than ultrasound when applied in addition to home exercises. Both groups improved, but the acupuncture group had a larger improvement in the combined score, (Johansson, 2005). This randomized control trial of iontophoresis and ultrasound for the treatment of calcifying tendinitis of the shoulder found no significant difference between groups for any of the variables measured, (Perron, 1997). The goal of this study was to compare short- and long-term outcomes of patients with rotator cuff calcific tendonitis who received or did not receive ultrasound-guided percutaneous treatment. This was administered with the patients under local anesthesia, by use of two 16-gauge needles that were inserted into the calcific deposit. Saline solution was injected through 1 needle, allowing aspiration of the dissolved calcium through the other needle. Recovery time was approximately 1 hour. The investigators concluded that patients who received ultrasound-guided percutaneous treatment had prompt pain relief and recovery of shoulder function, and their outcomes at 1 year were better than those of nontreated patients. At 5 and 10 years, however, outcomes were similar in both groups. According to the authors, for people with calcific tendonitis, a simple, one-time ultrasound-guided procedure could help them recover completely from the terrible pain constantly affecting their shoulder. This treatment could completely replace other treatments that are affected by several limitations and complications, (Serafini, 2009). The patient was diagnosed with adhesive capsulitis; ODG guidelines do not recommend the use ultrasound therapy in case of adhesive capsulitis. Therefore, the request is not medical necessary.

Supplies and materials, unspecified shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213-214.

Decision rationale: There is no specification of the type of supplies requested. Therefore, the request is not medically necessary.