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| <b>Case Number:</b>   | CM15-0036468 |                              |            |
| <b>Date Assigned:</b> | 03/05/2015   | <b>Date of Injury:</b>       | 02/14/2012 |
| <b>Decision Date:</b> | 04/13/2015   | <b>UR Denial Date:</b>       | 02/10/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/26/2015 |

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 40 year old female, who sustained an industrial injury on 02/14/2012. The diagnoses have included thoracic sprain/strain injury, lumbosacral sprain/strain injury, contusion injury involving thoracic and lumbosacral spine, possible thoracic and lumbosacral disc injury, and myofascial pain syndrome. Noted treatments to date have included exercise and medications. No MRI report noted in received medical records. In a progress note dated 01/29/2015, the injured worker presented with complaints of ongoing pain in the neck, mid-back, and left shoulder. The treating physician reported significant tightness around left rhomboid musculature. Utilization Review determination on 02/10/2015 non-certified the request for Infrared, Electro Acupuncture 2xWk x 6wks of Bilateral Wrist, and Myofascial Release citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Infrared:** 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 rationale:** Regarding the requested infrared, it appears that this is to be utilized in conjunction with acupuncture, and as acupuncture is not medically necessary, infrared is also not medically necessary.

**Myofascial release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 60 of 127.

**Decision rationale:** Regarding the request for myofascial release, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, the patient is noted to have previously received physical medicine treatment, which typically includes some form of massage/myofascial release, and no indication of functional improvement was documented. Furthermore, an open-ended request for treatment is not supported and, unfortunately, there is no provision for modification of the current request to a specific number of sessions. In the absence of clarity regarding the above issues, the currently requested myofascial release is not medically necessary.

**Electro acupuncture 2 times a week for six weeks of bilateral wrist:** Upheld

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

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

**Decision rationale:** Regarding the request for additional acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as “either a clinically significant improvement in activities of daily living or a reduction in work restrictions” and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears the patient has undergone acupuncture previously, but there is no documentation of objective functional improvement from the therapy already provided. As such, the currently requested acupuncture is not medically necessary.