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| Case Number: | CM14-0211277 | | |
| Date Assigned: | 12/24/2014 | Date of Injury: | 06/02/2011 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 12/01/2014 |
| Priority: | Standard | Application Received: | 12/17/2014 |

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. 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: Chiropractor, Oriental 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 57 year old male who reported shoulder pain from injury sustained on 06/02/11 while lifting heavy weight. Patient is diagnosed with status post arthroscopic right shoulder surgery with residual pain and dysfunction; sprain/strain of unspecified site of shoulder/upper arm; history of occult rotator cuff tear. Patient has been treated with 2 arthroscopic surgeries, medication, therapy, and acupuncture. Per medical notes dated 08/13/14, patient complains of right shoulder pain rated at 4/10, which is constant and mild. Right shoulder pain increases with ADLs, and decreases with medication. Examination revealed tenderness to palpation of right upper trapezius with spasms. Per medical notes dated 10/22/14, patient complains of right shoulder pain rated 3/10. Per utilization review, patient has had prior acupuncture treatment. Provider requested acupuncture and infrared which was non-certified by the utilization review. 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:

Infrared, electric acupuncture: 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: 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. Per utilization review, patient has had prior acupuncture treatment. Provider requested acupuncture and infrared which was non-certified by the utilization review. 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. California MTUS Chronic Pain treatment guidelines do not address infrared therapy 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, electric acupuncture and infrared are not medically necessary.