

<b>Case Number:</b>	CM15-0017461		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	10/10/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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

### 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 27 year old female, who sustained an industrial injury on 10/10/2013. The diagnoses have included myofascial pain syndrome, cervical strain, right shoulder strain, and possible neuropathy. Treatment to date has included physical therapy and medications. Home exercise has been encouraged. EMG (electromyography)/NCV (nerve conduction studies) dated 9/16/2014 revealed no electro diagnostic evidence of right carpal tunnel syndrome, cubital tunnel syndrome or cervical radiculopathy. Magnetic resonance imaging (MRI) of the cervical spine dated 10/08/2014 was described as normal. Currently, the IW complains of depression, anxiety, stress and difficulty sleeping secondary to pain and discomfort. She reported constant dull neck pain rated as 7/10 and associated with headaches. She also reported constant right upper extremity, right hand and shoulder pain associated with numbness and tingling and rated as 8-9/10. Objective findings included spasm and tenderness to the cervical spine with positive myofascial trigger points. Range of motion is decreased in the right shoulder and Tinel's sign is positive for the right wrist. On 1/12/2015, Utilization Review non-certified a request for electroacupunctuire infrared light, myofascial release (2x3) for the right wrist and right shoulder and EMG(electromyography)/NCS (nerve conduction studies) of the right upper extremity, noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS, ACOEM Guidelines and ODG were cited. On 1/29/2015, the injured worker submitted an application for IMR for review of electroacupunctuire infrared light, myofascial release (2x3) for the right wrist and right shoulder and EMG/NCS of the right upper extremity.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electro acupuncture, infrared light:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): 13.

**Decision rationale:** According to the 12/31/2014 report, this patient presents with neck pain and right shoulder pain. The current request is for electro acupuncture infrared light. The request for authorization is not provided for review. The patient's work status is to "remains temporarily partially disabled. No repetitive use of right hand activity. No heavy lifting, pushing, or pulling more than 5 pounds." For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain suffering and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement, with optimal duration of 1 to 2 months. In reviewing the provided reports, the medical records from 07/30/2014 to 12/31/2014 reports indicate that the patient has had acupuncture treatments with temporary benefit; however, the time frame and the number of sessions previously completed is unknown. In this case, the treating physician has asked for acupuncture but fails to specify the quantity of sessions requested and does not provide a medical rationale for the request. The request IS NOT medically necessary.

**Myofascial release 2 x 3 = right wrist and R shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** According to the 12/31/2014 report, this patient presents with neck pain and right shoulder pain. The current request is for myofascial release (2x3) for the right wrist and right shoulder. For massage therapy, the MTUS guideline page 60, "recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." In this case, review of the provided medical reports does not show any sessions of massage therapy or any discussions thereof. It is possible the patient has had massage therapy in the past with the documentation not provided. However, given that the review of the current reports make no reference to a recent course therapy, a short course may be reasonable. MTUS supports 4-6 sessions of massage therapy in most cases. The request IS medically necessary.

**EMG NCS RUE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Nerve Conduction studies (NCS) and Electrical muscle stimulation (EMS) Neck and Upper Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

**Decision rationale:** According to the 12/31/2014 report, this patient presents with chronic neck pain and right shoulder pain. The current request is for EMG/ NCS RUE. The medical reports provided for review indicates that the patient had EMG studies on 09/16/2014 with the impression of "no electrodiagnostic evidence of right CTS cubital tunnel syndrome or cervical radiculopathy." Regarding electrodiagnostic studies, the ACOEM supports it for upper extremities to differentiate CTS vs. radiculopathy and other conditions. The ODG guidelines further states state "If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." In reviewing the provided reports, the treating physician does not provide a medical rationale for the request, the treatment plan simply states "I have recommended the following treatment: EMG of upper extremity." In this case, a repeat study of the same body parts is not recommended. The treating physician does not explain why another study is needed when the previous EMG study was perform less than 3 month ago. There is no documentation of any significant worsening of this patient's condition, no new injury or diagnosis is provided and there are no red flags documented to indicate the need for a repeat EMG. Therefore, the request IS NOT medically necessary.