

<b>Case Number:</b>	CM15-0113553		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	08/30/2012
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 46 year old female who sustained an industrial injury on August 30, 2012. She complains of injury to the right shoulder and has been diagnosed with internal derangement, right shoulder, status post-surgery, details not known and probable reflex sympathetic dystrophy/ Chronic regional pain syndrome. Treatment has included medication, physical therapy, injections, surgery, medical imaging, chiropractic care, and acupuncture. Examination showed very limited range of motion to the right shoulder. There was tenderness to the proximal arm and swelling. There was hypersensitivity. The treatment request included acupuncture and spinal cord stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture for twelve sessions for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 9 Shoulder Complaints Page(s): 92, 204, Acupuncture Treatment Guidelines.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on acupuncture states: 1) "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. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Frequency and duration of acupuncture with electrical stimulation may be performed as follows: 1. Time to produce functional improvement 3-6 treatments; 2. Frequency: 1-3 times per week; 3. Optimum duration is 1-2 months; 4. Treatments may be extended if functional improvement is documented. The request for acupuncture is for a total of 12 sessions. This is in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments for more sessions to be certified. Therefore, the request is in excess of the recommended initial treatment sessions and not medically necessary.

**Anesthesia Evaluation for Spinal Cord Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator (SCS). Decision based on Non-MTUS Citation ACOEM 2004 OMPG, Independent Medical Examinations and Consultations ch7 page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulators Page(s): 106-107.

**Decision rationale:** The California MTUS section on spinal cord stimulators states: Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.) Post amputation pain (phantom limb pain), 68% success rate-Post herpetic neuralgia, 90% success rate-Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury). Pain associated with multiple sclerosis. Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004) The California MTUS also requires a psychological assessment and clearance before the procedure. This is not documented in the provided clinical documentation for review. Therefore, the need for anesthesia evaluation is not medically necessary as the procedure has not been cleared. The request is not medically necessary.

