

Case Number:	CM13-0069265		
Date Assigned:	01/03/2014	Date of Injury:	12/30/2012
Decision Date:	06/11/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/23/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 50-year-old who reported an injury on December 30, 2012, due to a slip and fall. The injured worker reportedly sustained an injury to her neck, right hand, upper back, mid-back, low back, and right leg. The injured worker's treatment history has included physical therapy, multiple medications, activity modifications, acupuncture, and epidural steroid injections. The injured worker was evaluated on November 6, 2013. It was documented that the injured worker had low back pain rated at a 7/10 and right wrist pain rated at a 5/10. Physical findings included decreased range of motion of the right wrist secondary to pain. Neurological testing documented that there was decreased sensation in the L5-S1 dermatome, with a decreased right-sided Achilles reflex. Evaluation of the wrist documented tenderness to palpation with a positive right-sided Phalen's test and restricted range of motion secondary to pain. Evaluation of the lumbar spine documented limited range of motion secondary to pain, with a positive straight leg raise test bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

MYOFASCIAL RELEASE, TWICE WEEKLY FOR SIX WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy..

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines, recommends up to six visits of massage therapy as appropriate treatment to assist with muscle relaxation and joint mobilization. The request exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. The request for myofascial release, twice weekly for six weeks, is not medically necessary or appropriate.

CHIROPRACTIC MANIPULATIVE THERAPY (CMT) 3-4 AREAS ONE (1) TIME A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulations, Page(s): 58.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, does recommend a trial of 6 visits of manipulative therapy for injured workers with low back pain. However, the clinical documentation indicates that the injured worker's other affected areas include the wrist. California Medical Treatment Utilization Schedule does not recommend manipulation therapy for the wrist. The request as it is submitted does not clearly identify what body parts would be treated, the appropriateness of the request cannot be determined. The request for CMT, three to four areas, once weekly for six weeks, is not medically necessary or appropriate.

WORK CONDITIONING TWO (2) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning, Work Hardening..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning, Page(s): 125.

Decision rationale: California Medical Treatment Utilization Schedule recommends up to ten visits over eight weeks of work conditioning when injured workers require physical medicine programs beyond what is provided during traditional physical therapy. The clinical documentation submitted for review does indicate that the injured worker has previously participated in physical therapy and continues to have functional deficits. However, the request exceeds the ten visit recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the request as it is submitted does not clearly identify a body part. Therefore, the appropriateness of the request itself cannot be determined. The request for work conditioning, twice weekly for six weeks, is not medically necessary or appropriate.

LUMBAR SUPPORT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The American College of Occupational and Environmental Medicine did not support the use of lumbar supports in the management of acute or chronic back pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. The request for lumbar support is not medically necessary or appropriate.

ELECTROMUSCULAR STIMULATION (EMS), TWICE PER WEEK FOR SIX WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Neuromuscular Electrical Stimulation (NMES Devices), Page(s): 121.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not recommend the use of electromuscular stimulation for the management of chronic pain. This treatment modality is supported when used in a rehabilitation program for stroke victims. The clinical documentation submitted for review does not indicate that the injured worker is a stroke victim that would benefit from this type of therapy. The request for EMS, twice per week for six weeks is not medically necessary or appropriate.