

Case Number:	CM14-0012893		
Date Assigned:	02/21/2014	Date of Injury:	10/05/2005
Decision Date:	07/10/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/31/2014

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. 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 53-year-old male who reported an injury on 10/05/2005 secondary to a motor vehicle accident. His diagnoses include lumbar sprain/strain, lumbosacral radiculopathy, and lumbosacral disc injury. According to the medical records submitted for review, the injured worker has been treated previously with medications and an unknown duration of electroacupuncture treatment. The injured worker was evaluated on 01/02/2014 and reported pain of unknown severity in the low back and leg. On physical examination, he was noted to have a positive straight leg raise on the left leg, decreased sensation of the left leg, and normal motor strength in the lower extremities bilaterally. His current medications were noted to include morphine and Norco. The injured worker was recommended for continued medications, additional electroacupuncture treatment, and a functional restoration program. The documentation submitted for review failed to provide a request for authorization form.

IMR ISSUES, DECISIONS AND RATIONALES

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

INFRARED MYOFASCIAL RELEASE, LOWER BACK 97026: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58,59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Infrared therapy (IR).

Decision rationale: The request for infrared myofascial release, for the lower back is not medically necessary. The California MTUS Guidelines may recommend massage therapy up to 6 visits for attenuating diffuse musculoskeletal symptoms. These guidelines state that massage is a passive intervention and treatment dependence should be avoided. These guidelines also state that treatment should be an adjunct to a structured exercise program. Although the most recent clinical note indicates that a request for a functional restoration program was submitted, there is a lack of documented evidence that the injured worker has participated in a standard physical therapy program or home exercise program. Additionally, the request as written does not include a quantity of visits for infrared myofascial release. Therefore, it cannot be determined that the request is supported by the evidence based guidelines for treatment duration. Additionally, the Official Disability Guidelines do not recommend infrared therapy over other heat therapies. There are no exceptional factors documented to indicate that the injured worker is unable to benefit from other heat therapies, and there is no documented rationale for the request for infrared therapy. As such, the request for infrared myofascial release for the lower back is not medically necessary or appropriate.