

Case Number:	CM14-0110552		
Date Assigned:	08/01/2014	Date of Injury:	02/20/2014
Decision Date:	09/03/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/15/2014

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 Nevada. 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 records presented for review indicate that this 46-year-old female was reportedly injured on February 20, 2014. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated June 3, 2014, indicates that there are ongoing complaints of pain of the cervical, thoracic, and lumbar spine as well as bilateral shoulder pain. The physical examination demonstrated normal spinal range of motion with pain. There was tenderness along the thoracic and lumbar paravertebral muscles. There was a positive bilateral straight leg raise test. Examination of the right shoulder noted decreased range of motion with pain. There was normal range of motion of the left shoulder. Bilaterally, there was tenderness over the acromioclavicular joint, anterior shoulder, posterior shoulder, and supraspinatus. There was a positive supraspinatus press test. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes physical therapy for the cervical, thoracic, and lumbar spine as well as oral medications. A request had been made for chiropractic care, physical therapy, and massage therapy and was not certified in the pre-authorization process on June 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 1-2 per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines supports the use of chiropractic care for low back pain as an optional treatment. There should be a trial of six visits over two weeks time to assess the evidence of objective functional improvement prior to continuing therapy. As this request is for 1 - 2 visits per week for four weeks, this request for chiropractic care is not medically necessary.

Physical therapy 1-2 per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine/passive therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

Decision rationale: According to the attached medical record the injured employee has previously participated in physical therapy for the spine. There is no attached documentation of the efficacy of these prior treatments or why there has not been a transition to home exercise. For these reasons, this request for physical therapy once or twice a week for four weeks is not medically necessary.

Massage therapy with modalities 1-2 per week for 4 weeks for lumbar, cervical, thoracic, right foot: Upheld

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

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

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. Additionally treatment is recommended to be limited to 4 to 6 visits in most cases. As this request is for 1 to 2 visits for four weeks time, this request for massage therapy for the cervical, thoracic, and lumbar spine as well as the right foot is not medically necessary.