MAXIMUS Federal Services

Case Number:	CM14-0040384		
Date Assigned:	06/20/2014	Date of Injury:	12/15/1989
Decision Date:	07/17/2014	UR Denial Date:	03/01/2014
Priority:	Standard	Application Received:	03/10/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine, 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:

This is a male patient with the date of injury of December 15, 1989. A Progress Report dated February 20, 2014 identifies Subjective findings of cervical pain radiating to right shoulder, right posterior scapula, right elbow, and right hand and lumbar pain radiating to right buttock, right posterior thigh proximal to posterior knee. Objective findings identify decreased cervical, thoracic, and lumbar range of motion. Moderate tenderness to palpation. Sensation decreased right C6 and S1. Trigger points bilateral lumbar paraspinal area. Diagnoses identify myofascial/myalgia unspecified, cervical cephalgia/encephalgial, cervical degenerative disk disease, cervical disk degeneration, hypogonadism, and lumbar fusion T11-S1. Treatment & Plan identifies manipulation 3-4 areas 1x/week for 4 weeks, massage 30 minutes. Short term goals identify increased joint movement, decrease pain, and decrease tenderness. Long term goals identify able to perform functional activities with less difficulty.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 chiropractic manipulation sessions: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 58-60 of 127.

Decision rationale: Regarding the request for 4 chiropractic manipulation sessions, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is no indication of objective functional improvement with previous sessions. In addition, the number of sessions completed to date is unknown. In the absence of clarity regarding the above issues, the currently requested 4 chiropractic manipulation sessions is not medically necessary.

4 massage therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 60 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Massage Therapy.

Decision rationale: Regarding the request for 4 massage therapy sessions, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to the number of massage therapy visits the patient has previously undergone. Furthermore, there is no documentation of objective functional improvement from the therapy sessions already authorized. In the absence of clarity regarding those issues, the currently requested 4 massage therapy sessions is not medically necessary.