

Case Number:	CM14-0046978		
Date Assigned:	07/02/2014	Date of Injury:	03/22/2014
Decision Date:	08/01/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/14/2014

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 licensed in Chiropractic Care and is licensed to practice in Texas. 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 female who reported an injury on 03/22/2012 from a fall landing on her left side. The injured worker had a history of lower back pain with a diagnosis of chronic pain syndrome, lumbar degenerative disc disease, and lumbar myositis. The injured worker is taking ibuprofen with dosage not provided. The injured worker rated her lumbar pain at a 7/10 using the VAS scale. The physical examination of the lumbar revealed deep tendon reflexes plus 2, straight leg raise negative, and tenderness on palpation over the L3-S1. The treatment plan includes physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, 6 months of cardio, core strengthening, yoga, massage therapy twice a week for 12 weeks, chiropractic once a week for 12 weeks, daily walking, and follow up in one month. The authorization form dated 07/02/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 1x12 for low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 153-154, 298-299, Chronic Pain Treatment Guidelines Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Back Chapter.

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

Decision rationale: MTUS Guidelines state that manual therapy and manipulation may be recommended to achieve objective measurable functional gains and facilitate progression in therapeutic exercise programs. For the lumbar spine, the guidelines may support a total of 18 visits, without evidence of objective functional improvement after an initial trial. The clinical information submitted for review indicated that the injured worker would be utilizing chiropractic treatment as an adjunct to physical therapy. However, the injured worker was not shown to have current objective functional deficits, and sufficient evidence of functional improvement with her previously completed 26 sessions of chiropractic care was not provided. In addition, no exceptional factors were provided to warrant additional chiropractic sessions as the injured worker has already exceeded the number of sessions recommended by guidelines. As such, the request is not medically necessary.

Massage therapy 2x12 for low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300, Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60, 180-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Back Chapter, Massage; Neck and Upper Back Chapter, Massage.

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

Decision rationale: MTUS Guidelines state that massage therapy is a passive modality which should be an adjunct to other recommended active treatments, and it should be limited to 4-6 visits in most cases. The documentation provided indicated that the patient would be participating in active treatments concurrently with the request; however, 2 treatments per week for 12 weeks exceeds the guideline's recommendation for a maximum of 4-6 visits. As such, the request is not medically necessary.