

Case Number:	CM14-0208633		
Date Assigned:	12/22/2014	Date of Injury:	09/15/2012
Decision Date:	02/17/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/12/2014

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 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 patient is a 44 year old female with date of injury 09/15/12. The treating physician report dated 10/21/14 (38) indicates that the patient presents with low back, right shoulder and neck pain. The patient states that the pain is constant. The neck pain radiates up her neck and to the occiput region of her head that worsens with overhead lifting and bending. She is seeing a chiropractor and has completed 6 sessions, and states it was not beneficial. The patient is currently prescribed Diclofenac, Tramadol, and Lidocaine. There was no physical examination documented on the visit dated 10/21/14. The current diagnoses are: 1. Rotator cuff injury 2. Regional myofascial pain syndrome of the neck and shoulder girdle 3. Disc Disorder Lumbar 4. Chronic Pain Syndrome 5. Low Back Pain. The utilization review report dated 11/19/14 denied the request for myofascial therapy based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofascial Therapy 2x3 for Neck and Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, pain Chapter, Myofascial Pain

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

Decision rationale: The patient presents with neck, low back, and right shoulder pain. The current request is for Myofascial Therapy 2x3 for Neck and Right Shoulder. The treating physician indicates that "Patient has responded previously to Myofascial Therapy: goal is to reduce pain and improve function." There is no indication as to how many sessions of myofascial therapy that patient underwent or when they were received. The MTUS guidelines state that massage therapy is recommended as an option as an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. In this case, the patient has already received myofascial therapy and the guidelines only recommend 4-6 visits so an additional 6 visits would exceed the MTUS guidelines. Recommendation is for denial as the request for additional sessions is not supported by the MTUS guidelines.