

Case Number:	CM15-0214899		
Date Assigned:	11/04/2015	Date of Injury:	12/08/2006
Decision Date:	12/21/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	11/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Arizona, California
 Certification(s)/Specialty: Family Practice

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 54 year old female, who sustained an industrial injury on 12-8-2006. The medical records indicate that the injured worker is undergoing treatment for right shoulder lesion, pain in right arm, and major depressive disorder. According to the progress report dated 10-7-2015, the injured worker presented with complaints of right trapezius and right elbow pain. On a subjective pain scale, she rates her pain 5-8 out of 10. The physical examination of the right shoulder reveals tenderness to palpation over the trapezius. Movements are restricted with abduction, limited to 110 degrees due to pain. The current medications are Terocin patch, Omeprazole, Risperidone, Topamax, Zolof, and Baclofen. Treatments to date include medication management, home exercises, chiropractic, and myofascial therapy. With myofascial therapy, the treating physician stated that she "has had benefit in the past from this treatment and has had improved sleep and decreased night time waking". Work status is described as permanent and stationary. The original utilization review (10-5-2015) had non-certified a request for myofascial therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofascial therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

Decision rationale: According to the guidelines, myofascial therapy is recommended for up to 4-6 visits. In this case, the claimant completed an unknown amount of sessions in the past. The claimant has also completed chiropractor therapy and home exercise. The request for an additional 6 sessions exceeds the guidelines recommendations and is not medically necessary.