

<b>Case Number:</b>	CM14-0146979		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	01/24/2014
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 licensed in Chiropractic 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 48 year old male who was injured on 01/24/2014 while installing windows into a truck for his job. He felt a pull on the right side of his groin and also the left. The patient underwent a herniorrhaphy on 06/03/2014. Progress report dated 08/18/2014 documented the patient to have complaints of severe intractable pain and he was also limping. The patient reported difficulty rising from a seated position to a standing position. His movements were guarded and stiff in the back. He complained of mid back pain as well as hip and groin pain bilaterally radiating to bilateral thighs. He rated the pain as a 7/10. On exam, he had lumbar spine curvature on the left, thoracic spine curvature on the right, pelvic elevated iliac crest on the left, lumbopelvic tilt down on the right; thoracic muscle tension bilaterally; lumbar muscle tension bilaterally; lumbopelvis muscle tension bilaterally; thoracic hyperkyphosis bilaterally; and lumbar hypolordosis bilaterally. the patient was diagnosed with thoracolumbar myofascial pain syndrome; lumbar disk syndrome with myelopathy; lumbar myofascial pain syndrome; lumbosacral pain syndrome; pelvic sprain/strain syndrome; sacroiliac impingement syndrome; inguinal hernia; umbilical hernia; and inguinal bilateral hernia. He was recommended for chiropractic treatment twice a week for 6 weeks. Prior utilization review dated 09/03/2014 states the request for Chiropractic physiotherapy two times a week for six weeks for the groin, pelvis, lumbar spine and hip is modified to certify 6 sessions of treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic physiotherapy two times a week for six weeks for the groin, pelvis, lumbar spine and hip:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Groin, pelvis, lumbar spine and hip, Manipulation

**Decision rationale:** The CA MTUS guidelines allows for a trial of 6 Chiropractic visits within the first two weeks of an injury with additional treatments available provided there has been documented measurable improvements in functional capacity. "CA MTUS- Low back: Recommended as an option Therapeutic care- Trial of 6 visits over 2 weeks with evidence of objective functional improvement, total of up to 18 visits over a 6-8 week."The request for 12 treatments on a 2x week for 6 weeks falls outside the treatment guidelines for both the number of treatments requested as well as time allowed for receiving such treatment for maximum benefit to the patient. This request, therefore is not medically necessary.

**Massage therapy two times a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS MANUAL THERAPY & MANIPULATION Page(s): 60-127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Groin, pelvis, lumbar spine and hip, Massage.

**Decision rationale:** Per the CA MTUS guidelines, massage therapy is recommended as an option when used in conjunction with exercise programs. ODG's recommended frequency and duration of treatment for massage therapy are the same as manipulation: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. There is no documentation found within the patient's record of being or having been transitioned into an HEP or currently actively in an exercise program. Additionally, there is a lack of documentation outlining improvement in functional capacity resulting from prior treatment nor what benefit would be derived by continued treatment. The request for massage therapy on a 2x per week for 6 weeks basis falls outside the CA MTUS guidelines as stated above and therefore is not medically necessary.