

Case Number:	CM15-0013615		
Date Assigned:	02/02/2015	Date of Injury:	01/18/2013
Decision Date:	03/18/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/23/2015

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: California

Certification(s)/Specialty: Emergency Medicine

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 30 year old female who sustained an industrial injury reported on 1/18/2013. Mechanism of injury is not provided. She has reported low back and left shoulder pain. The diagnoses have included L shoulder rotator cuff tear, left lumbosacral sprain/strain; lumbosacral radiculopathy; and low back and leg flare-ups. Treatments to date have included consultations; diagnostic laboratory and imaging studies; physical therapy; electro-acupuncture therapy/ myofascial release therapy; epidural steroid injection; transcutaneous electrical stimulation unit; exercise; and medication management. The work status classification for this injured worker (IW) was noted to be returned to work with restrictions. Last office dated 1/5/15 reports L shoulder pain. Pain is moderate. Objective exam reveals L shoulder pain to palpation, Decreased range of motion. Deltoid and rotator cuff strength is 4/5. Patient has received an unknown number of prior manipulation and chiropractic sessions with "improvement" but total number was not documented and response was not documented. Medications listed is Norco and Lodine. Also uses topical cream. On 1/7/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/17/2014, for continuation of myofascial release, 2 x a week x 6 weeks (#12), lumbar spine. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines, manual therapy and manipulation, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofascial Release 2xWK x6Wks Lumbar Spine: Upheld

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

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

Decision rationale: As per MTUS Chronic pain guidelines, manual therapy is recommended as an option. It recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, up to a total of up to 18 visits over 6-8 weeks. Provider has failed to provide any documentation of any objective functional improvement from prior treatment. Vague terms like "beneficial" and "improvement" are not valid. Myofascial release is not medically necessary.