

Case Number:	CM15-0072028		
Date Assigned:	04/22/2015	Date of Injury:	09/18/2001
Decision Date:	06/11/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/15/2015

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: Physical Medicine & Rehabilitation

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 (IW) is a 63 year old male who sustained an industrial injury on 09/18/2001. There is no documentation within the records made available of the type or extent of the orthopedic injury. A QME report of August 2009 is inclusive only of a comprehensive cardiovascular evaluation performed 5/14/2009. The documentation presented requests approval of 2 monthly Chiropractic visits and 1 monthly massage for the IW for six months requests a continuation of treatment. Documentation describes the worker's subjective complaints as a flare up of low back pain in the lower center of the lumbar spine with radicular symptoms in the right lower extremity rated an 8/10. He has cervico-cranial pain and a headache rated a 5/10, and complains of pain into the right trapezius and shoulder pain rated a 6/10. Diagnoses listed are Lumbar disc disorder; segmental dysfunction, thoracic spine; neuralgia, right leg; myofibrositis; shoulder bursitis/tendonitis; late effect of sprain/strain injury (all diagnosis chronic). The treatment plan requests the above described Chiropractic and massage therapy stating the worker receives positive relief with spinal manipulation and physiotherapy and cervical spine treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Chiropractic Therapy 2 times per month over 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

Decision rationale: MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved work/functional status from treatment already rendered by previous chiropractic care. Clinical exam remains unchanged without acute red-flag findings. It appears the patient has received an extensive conservative treatment trial; however, remains unchanged without functional restoration approach. The Outpatient Chiropractic Therapy 2 times per month over 6 months are not medically necessary and appropriate.

Massage therapy one time a month over 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter, Myofascial Pain/therapies, page 772-773.

Decision rationale: Massage is recommended for time-limited use in subacute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises; however, this is not the case for this chronic injury status post significant conservative physical therapy currently on an independent home exercise program without plan for formal physical therapy sessions. The patient has been deemed P&S and remains not working. A short course may be appropriate during an acute flare-up; however, this has not been demonstrated nor are there any documented clinical change or functional improvement from treatment rendered previously. Without any new onset or documented plan for a concurrent active exercise program, criteria for massage therapy have not been established per MTUS Chronic Pain Guidelines. The Massage therapy one time a month over 6 months is not medically necessary and appropriate.