MAXIMUS Federal Services

Case Number:	CM13-0044398		
Date Assigned:	12/27/2013	Date of Injury:	08/19/2002
Decision Date:	02/27/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pediatric Rehabilitative Medicine and is licensed to practice in Illinois and Texas. 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 physician 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 57-year-old who reported an injury on 08/19/2002. The mechanism of injury was not submitted. The patient was diagnosed with low back pain, chronic pain due to trauma, failed back surgery syndrome, myalgia and myositis unspecified, COAT, thoracic or lumbosacral radiculopathy, and degenerative disc disease. The patient complained of mild to moderate low back pain. The patient also complained of radiating pain to the left ankle, left calf, right calf, left foot, and right thigh. The patient characterized the pain as an 8, burning, discomforting, sharp, shooting, stabbing, and throbbing. Symptoms are aggravated by ascending stairs, bending, daily activities, jumping, lifting, lying/rest, pushing, rolling over in bed, running, sitting, standing, and twisting. Symptoms are relieved by heat, ice, lying down, pain medication, stretching, and rest. The patient rated her pain at 9/10. The physical examination of the lumbar spine revealed decreased range of motion and tenderness with iliac crest. The patient had prior epidural steroid injections, trigger point injections, and TENS (transcutaneous electrical nerve stimulation) without lasting relief. The patient was recommended massage therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

massage therapy, once per week for ten weeks, for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends massage therapy as a treatment and should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Guidelines also state massage is a passive intervention and treatment dependence should be avoided. The patient continued to complain of pain to the low back rated at a 9/10. However, the clinical documentation submitted for review does not indicate that the patient is participating in physical therapy or a home exercise program. Also, the request exceeds the guidelines recommendations. The request for massage therapy, once per week for ten weeks, for the lumbar spine, is not medically necessary or appropriate.