

<b>Case Number:</b>	CM14-0001007		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	11/26/2011
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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 Board Certified in Anesthesiology, has a subspecialty in Pain Management 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 49-year-old female who has submitted a claim for spinal stenosis, lumbar region, without neurogenic claudication associated with an industrial injury date of November 26, 2011. The patient complains of back pain aggravated by increased activity. The most recent physical examination showed limitation of motion of the lumbar spine. The diagnoses include thoracic strain, lumbar strain, lumbar spondylosis L2-L3, L3-4, and L4-5, disc protrusions at T11-T12, L2-L3, L3-L4, and L4-L5, moderate bilateral lateral recess, moderate right and left neural foraminal stenosis L3-L4, moderate central and moderate to severe bilateral lateral recess stenosis, moderate to severe right and mild left neural foraminal stenosis L4-L5, 2mm central disc protrusion T5-T6 and 2-3mm left paracentral disc protrusion T11-12. The treatment plan includes requests for physical therapy and massage therapy with focus on core strengthening and instruction in an independent home exercise program. There was also a request for a medical transportation. The treatment to date has included oral and topical analgesics, acupuncture, TENS, muscle relaxants, and physical therapy. The utilization review from December 18, 2013 denied the requests for massage therapy sessions QTY 6.00 because the body area was not stated and medical transportation QTY 1.00 because this is not a medical treatment. The request for physical therapy sessions, lumbar spine 2x6 weeks QTY 12.00 was modified to 1x3 weeks QTY: 3 to specifically review, instruct and reinforce the home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 PHYSICAL THERAPY SESSIONS FOR THE LUMBAR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 2009 Page(s): 98-99. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK PAIN CHAPTER, PHYSICAL THERAPY

**Decision rationale:** Pages 98-88 of California MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is beneficial for restoring flexibility, strength, endurance, function, and range of motion. Patients are instructed and expected to continue active home therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition to this, ODG Low Back Pain Section, stated that there is strong evidence that physical method, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. The most effective strategy is delivering individually designed exercise programs in a supervised format, encouraging stretching and muscle strengthening exercises. A total of 10-12 visits over 8 weeks is recommended for thoracic/lumbosacral neuritis/radiculitis with a six-visit clinical trial. In this case, physical therapy was requested to facilitate core strengthening and provide instruction in independent home exercise program. The guideline recommends active therapy for strengthening exercises and for transitioning the patient into a home based exercise program. However, the requested number of visits exceeds the guideline recommendation. The guideline recommends a six-visit clinical trial with documentation of objective and measurable functional gains prior to continuation of treatment. The medical necessity has not been established at this time. Therefore the request for 12 physical therapy sessions for the lumbar is not medically necessary.

**6 MASSAGE THERAPY SESSIONS:** Upheld

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

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

**Decision rationale:** Page 60 of the California MTUS Chronic Pain Medical Treatment Guidelines state that massage therapy is an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. In this case, a massage therapy was requested to focus on core strengthening and instruction in an independent home exercise program, in conjunction with the requested physical therapy. However, the body part to receive the treatment was not specified. Therefore, the request for 6 massage therapy sessions is not medically necessary.

**MEDICAL TRANSPORTATION:** 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 OFFICIAL DISABILITY GUIDELINES (ODG) KNEE AND LEG CHAPTER, TRANSPORTATION (TO & FROM APPOINTMENTS)

**Decision rationale:** The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines was used instead. ODG states that medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport is supported. In this case, the patient was unable to tolerate driving from her home to the treatment facility. However, the request did not specify the number of times and the duration that the patient would need medical transportation. Alternate modes of transportation were not explored. Therefore, the request for medical transportation is not medically necessary.