

Case Number:	CM14-0154635		
Date Assigned:	09/24/2014	Date of Injury:	10/12/2013
Decision Date:	10/28/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/22/2014

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 Physical Medicine and Rehabilitation, 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:

This is a patient with a date of injury of October 12, 2013. A utilization review determination dated September 2, 2014 recommends noncertification of lumbar massage therapy. Noncertification was recommended due to a lack of objective gains from prior treatment including changes in range of motion, strength, or functional activity tolerance. A progress report dated August 15, 2014 identifies subjective complaints of low back pain with radiculopathy. The patient has undergone physiotherapy and currently uses a back brace. He complains of pain rated as 10/10 and right leg numbness. He also gets cramps in his right leg. Objective examination findings identify numbness in the right side from the toes to the buttock which started 2 weeks ago. The pain has been excruciating when he coughed. His straight leg raise is positive at 4 and 5. Diagnoses include status post lumbar fusion at L5-S1 and bilateral radiculitis. The treatment plan recommends chiropractic/physical therapy 1 to 3 times a week for 2 weeks and massage therapy. Additionally, home exercise is recommended and continuing medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR MASSAGE THERAPY FREQUENCY/DURATION UNSPECIFIED RFA 8-15-14: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 60 OF 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Massage Therapy

Decision rationale: Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, it is unclear whether the patient has previously undergone massage therapy. If so, there is no documentation of any objective functional improvement as a result of that massage therapy. Additionally, it is unclear what objective treatment goals are hoping to be addressed with the currently requested massage therapy. Furthermore, it appears the patient has new onset numbness in the lower extremity. This may need to be addressed prior to any manual therapy. Finally, the currently requested massage therapy has no frequency or duration, and there is no provision to modify the current request. As such, the currently requested massage therapy is not medically necessary.