

Case Number:	CM14-0036800		
Date Assigned:	06/25/2014	Date of Injury:	10/22/1998
Decision Date:	07/23/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	03/26/2014

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 and is licensed to practice in California and Washington. 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 injured worker is a 53-year-old female who reported an injury on 10/22/1998. The mechanism of injury was noted to be a fall. The injured worker's prior treatments were noted to be massage, physical therapy, acupuncture, chiropractic care, epidural steroid injections, facet injections, water aerobics, weight program, gym exercise, and transcutaneous electrical nerve stimulation. Her diagnoses were noted to be neck pain, low back pain, knee pain, and probable impingement syndrome. Additional diagnoses were noted to be ulnar compressive neuropathy - status post resection, history of carpal tunnel syndrome - status post resection, bilateral ankle tendinopathy, bilateral knee meniscus, radial nerve dysfunction (right), and thoracic - lumbosacral neuritis or rheumatoid arthritis. The injured worker had a clinical evaluation on 02/13/2014. The injured worker had complaints of shoulder pain, neck pain, back pain, knee pain, wrist pain, ankle pain, hip pain, and sleep apnea. The clinical examination noted the injured worker to have vital signs within normal limits and pain rated at an 8 on a scale of 1 to 10. It was noted that the injured worker was alert and oriented. She had decreased sensation in digits 3 through 5 compared to 1 through 2 in her hands and along the outside of both of her feet. She had a negative straight leg raise and pain with extension and rotation; less pain with flexion. The plan of treatment included a recommendation for a medial branch block. The request for authorization for medical treatment was not included within the documentation. The provider's rationale for the requested home modification to laundry room and deep tissue massage once weekly for 3 months was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home modification to laundry room: 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, Durable medical equipment (DME).

Decision rationale: The request for home modification to laundry room is not medically necessary. The Official Disability Guidelines indicate some medical conditions that result in physical limitations may require patient education and modification to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The provider's request is not medical in nature. Therefore, the request for home modification to laundry room is not medically necessary.

Deep tissue massage once weekly times three months: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The request for deep tissue massage once weekly times 3 months is not medically necessary. The California MTUS American College of Occupational and Environmental Medicine Guidelines state that physical modalities such as massage have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short-term if used in conjunction with a program of functional restoration. The clinical evaluation on 02/13/2014 indicates prior use of massage therapy. The documentation fails to support a functional restoration program in place. It is noted that the injured worker continues to have chronic pain in her back according to the physical evaluation thus indicating no efficacy of prior massage. Therefore, the request for deep tissue massage once weekly times 3 months is not medically necessary.