

Case Number:	CM14-0074493		
Date Assigned:	10/01/2014	Date of Injury:	12/08/1999
Decision Date:	11/05/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/22/2014

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 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 injured worker is a 52 year old female with a date of injury on 12/8/1999. As per the report of 3/28/14, she complained of diffuse neck, low back, bilateral lower extremity and right hip pain. The pain described as an aching and a lancinating sensation with discomfort and exacerbated with increased activities and difficulty sleeping. She had compromised mood due to chronic pain. On exam, gait was mildly antalgic. Muscle strength was reduced in the plantar flexor muscles. She was not able to toe and heel walk. There were palpable taut bands in the area of the pain. There were soft tissue dysfunction and spasm in the thoracic paraspinal, lumbar paraspinal and gluteal region. Flexion of hip against resistance caused pain in her groin. Straight leg raising (SLR) of the affected side reproduced the radicular symptoms. Sensation of the region revealed dysesthetic sensations throughout the affected area. She appeared in depressed mood due to chronic pain. On 11/11/11 lumbar magnetic resonance imaging (MRI) showed disc disease at L4-5 and L5-S1 without nerve root encroachment. On 11/9/11 electromyography (EMG) showed left L5-S1 chronic radiculopathy. She had had lumbar laminectomy at L4-5 in 1988 and 2000. She is on Dilaudid, meloxicam, Topamax, Protonix, and Cymbalta. Previous treatment included physical therapy, chiropractic care, massage, acupuncture, injections, and transcutaneous electrical nerve stimulation (TENS) with benefit. The use of analgesic medications and various types of injection therapies provided partial relief. Diagnoses include lumbar or lumbosacral disc degeneration, thoracic or lumbosacral neuritis or radiculitis, not otherwise specified, obesity not otherwise specified, depressive disorder not elsewhere classified, chronic pain syndrome, osteoarthritis, not otherwise specified unspecified site, myalgia and myositis not otherwise specified, sleep disturbance not otherwise specified, electronic prescribing enabled, encounter for long-term use of other medications, depressive disorder no; elsewhere classified, obesity not otherwise specified, sleep disturbance otherwise specified, pain

in joint of pelvic region and thigh, pain in joint multiple sites. The request for therapeutic exercises was denied due to lack of medical necessity guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Massage Therapy Sessions (2 times a week for 6 weeks for the Lumbar Spine): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 303, Chronic Pain Treatment Guidelines Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy

Decision rationale: As per the California Medical Treatment Utilization Schedule (MTUS) guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The Official Disability Guidelines (ODG) recommends 9 visits over 8 weeks intervertebral disc disorders without myelopathy. In this case, the injury is very old and the injured worker has already received unknown number of physical therapy and chiropractic visits. However, there is no record of progress notes and there is no documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) with prior therapy to demonstrate the effectiveness of this modality in this injured worker. There is no evidence of presentation of any new injury/surgical intervention. Moreover, additional physical therapy visits would exceed the guidelines criteria. Furthermore, there is no mention of the injured worker utilizing a home exercise program (HEP). At this juncture, this injured worker should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels. Moreover, the number of requested treatments has not been specified. Therefore, the request is not medically necessary.