

Case Number:	CM14-0136897		
Date Assigned:	09/03/2014	Date of Injury:	03/30/2008
Decision Date:	09/24/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/25/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 45 year old female with a work injury dated 3/30/08. The diagnoses include cervical spinal strain with cervical radiculitis; history of bilateral carpal tunnel syndrome with right carpal tunnel release, 2 April 2008, and left carpal tunnel release, 12 May 2008; lumbar spine strain with lumbar radiculitis; status post sesamoidectomy, ulnar and radial sesamoid bones, right thumb, 27September 2013. Under consideration is a request for physical therapy for lumbosacral/right gluteal area, times 6 and massage therapy for lumbosacral/right gluteal area, times 6. Per a 5/20/13 evaluation during work on 11/20/11, the patient had inserted a Foley catheter into an unusually obese individual and experienced lumbar spine pain. The document notes that it should be mentioned that even before this, there were complaints of back pain, although to a far lesser extent. In approximately mid-2013, radiofrequency ablation was performed in the lumbar spine. The radiofrequency was helpful for approximately six months' duration. The majority of current pain is present in the lumbar spine. It is eccentric to the right side with pain referral into the right leg as far as the right popliteal region. This pain is continuous. It intensifies with sitting and actually decreases with walking. She indicated that she walks her two dogs for exercise on a regular basis. The back pain increases with bending activities. This pain is characterized by pain referral into the right buttock and hip region and, on occasion, into the right inguinal region. The pain also intensifies with lifting activities. Prior work injuries occurred in 2002 or 2003, low back injury while pushing gurney; 2005, carpal tunnel and upper extremity injury; 2006, carpal tunnel and upper extremity injury. On exam the patient uses assistive device. The standing posture is normal. Head carriage is normal and the shoulders are level. There is no evidence of scoliosis or spinal decompensation. The thoracic kyphosis and lumbar lordosis is preserved and within normal limits. The alignment of the lower

extremities is normal without evidence of abnormal genu varum or genu valgum. The musculature is normal in contour, without evidence of atrophy. There are no scars of significance or deformities. The gait is normal, without limp. Heel and toe walking are normal. The lumbosacral junction and right paralumbar areas are tender to direct palpation. The right greater than left buttock is tender to direct palpation. The bilateral lower extremity reflexes are normal. Neurosensory examination is within normal limits. The straight-leg raising test is negative in both seated and reclining positions. Sensory loss is present over the lateral aspect of the left calf. She experiences back, neck, and right hand pain. She also experiences paresthesias in the lower extremities. The patient experienced lumbar spine pain and was provided a new date of injury for the lumbar spine dated 20 November 2011. At an Agreed Medical Evaluation which took place on 28 August 2012, she had achieved maximum medical improvement for the lumbar spine. Levels of disability and impairment were calculated. Prior utilization review states that a document dated 06/03/14 indicates the patient complains of worsening pain in the right hip. It is hard to put weight on the right side. Physical examination shows tenderness above the area of the right sacroiliac joint and along the right buttock to the lateral aspect of the thigh. The provider recommends 6 sessions of physical therapy and massage therapy for the lumbosacral/right gluteal area.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for lumbosacral/right gluteal area, QTY: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: Physical therapy for lumbosacral/right gluteal area, times 6 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation for this review indicates that the patient's date of injury was in 2008. The documentation does not contain the office visit date associated with the request for massage and physical therapy. The documentation indicates that the patient has had prior lumbar issues and was deemed at maximal medical improvement for the lumbar spine in 2012. The patient should be versed in a home exercise program. Without clarification of how much prior therapy the patient has had for her low back and the outcome of this therapy as well as full supporting documentation of a need for 6 sessions of PT the request for physical therapy for lumbosacral/right gluteal area, times 6 is not medically necessary.

Massage therapy for lumbosacral/right gluteal area, QTY: 6: Upheld

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

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

Decision rationale: Massage therapy for lumbosacral/right gluteal area, times 6 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that massage should be limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. The documentation for this review indicates that the patient's date of injury was in 2008. The documentation does not contain the office visit date associated with the request for massage and physical therapy. The documentation is not clear on how much massage therapy the patient has had in the past for the lumbosacral area with a documented date of injury 2008. Without clarification of how much prior therapy the patient has had for her low back and the outcome of this therapy as well as full supporting documentation of a need for massage therapy the request for massage therapy for lumbosacral/right gluteal area, times 6 is not medically necessary.