

Case Number:	CM15-0018834		
Date Assigned:	02/06/2015	Date of Injury:	09/08/2010
Decision Date:	03/30/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50-year-old female with an industrial injury date of 09/08/2010. She presents for follow up on 01/19/2015 for follow up of bilateral upper extremity pain. She states she has been experiencing radiation of pain down her spine into her lumbar region. Physical exam revealed normal muscle tone without atrophy in both upper and lower extremities. Prior treatment included authorization for 12 sessions of acupuncture. The injured worker had 6 sessions and noted pain relief with acupuncture. Other treatments were massage therapy and physical therapy. Prior x-rays of the cervical spine dated 10/21/2010 showed some disc space narrowing at cervical 5-6. MRI of the cervical spine dated 10/10/2013 showed a 2 mm disc bulge at cervical 6-7 and a 2 mm disc bulge at cervical 4-5. Electro diagnostic studies dated 12/06/2010 of bilateral upper extremities were normal (per provider). The provider requested massage therapy and TENS unit. Diagnoses were: Sprains and strains of neck. Sprain/strain thoracic region. Syndrome-cervico-brachial. Carpal Tunnel Syndrome. Bilateral Epicondylitis lateral. Bilateral-DeQuervains Tenosynovitis. Bilateral. On 01/23/2015 utilization review issued a decision of non-certification of the request for six sessions of massage therapy. MTUS was cited. The request for TENS unit and supplies was also non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy; 6 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy.

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

Decision rationale: This patient presents with bilateral upper extremity pain and low back pain. The current request is for MASSAGE THERAPY; 6 SESSIONS. The MTUS Chronic Pain Medical Treatment Guidelines, page 60 for Massage therapy states: Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment, e.g. exercise, and it should be limited to 4-6 visits in most cases. The medical file provided for review includes progress reports from 9/11/14 through 2/19/15 and provide no discussion regarding prior massage therapy. The Utilization review states that the patient has massage therapy in the past, which were helpful and has allowed the claimant to remain at work, but there is not documentation of objection and functional improvement. In this case, the patient was able to remain working with prior massage therapy, which was performed concurrently with chiropractic treatment. The progress reports do not document any recent massage therapy sessions; therefore it is unclear when prior treatment was received. Given the patient's increase in pain and the efficacy of prior treatment, the requested 6 massage therapy sessions ARE medically necessary.

TENS unit and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS for chronic pain Page(s): 114-116.

Decision rationale: This patient presents with bilateral upper extremity pain and low back pain. The current request is for TENS UNIT AND SUPPLIES. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. When a TENS unit is indicated, a 30-home trial is recommended and with documentation of functional improvement, additional usage may be indicated. Progress report dated 12/10/14 states she has benefited from acupuncture and she has not benefited much from the TENS unit. In this case, the patient has been utilizing a TENS unit with no documentation regarding frequency of use, magnitude of pain reduction, and functional changes with prior use of TENS unit. MTUS allows for extended use of the unit when there is documentation of functional improvement. This patient does not meet the criteria for extended use; therefore, the requested TENS unit and supplies IS NOT medically necessary.

