

Case Number:	CM15-0026154		
Date Assigned:	02/20/2015	Date of Injury:	02/23/2012
Decision Date:	04/01/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/10/2015

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 53 year old female, who sustained an industrial injury on 2/23/2012. The diagnoses have included lumbar radiculopathy, chronic neck, mid back and low back pain, left shoulder arthralgia and left ankle arthralgia. Treatment to date has included chiropractic manipulation, aquatic therapy, acupuncture and medication. According to the progress report dated 8/29/2014, the injured worker was seen for follow-up of low back pain. The injured worker reported receiving a transforaminal epidural steroid injection (ESI) at the left L5 and S1 on 8/13/2014. She stated that the numbness, burning and swelling in her left leg had decreased significantly since the injection. She reported being able to walk for longer periods of time. She complained of achy low back pain which she rated 2/10 on the left and 3-4/10 on the right. Objective findings revealed a mildly antalgic gait. There was limited range of motion of the cervical, thoracic and lumbar spine. There was a positive straight leg raise on the left. Authorization was requested for massage therapy one time a week for eight weeks. The progress report dated 12/10/2014 documents that the injured worker had a history of massage therapy with relief; it helped to loosen up her back and allowed for her to do more activities. Current medications included Flexeril and Norco as needed. The injured worker complained of constant tightness and achiness in the low back, left worse than the right. She rated her low back pain as 4/10. Authorization was requested for medications, repeat epidural steroid injection (ESI) and massage therapy. On 1/29/2015, Utilization Review (UR) modified a request for Massage Therapy one time a week for eight weeks to Massage Therapy one time a week for six weeks. The Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy 1x8, lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter, Myofascial Pain/therapies, page 772-773.

Decision rationale: Massage is recommended for time-limited use in subacute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises; however, this is not the case for this chronic injury status post significant conservative physical therapy currently on an independent home exercise program without plan for formal physical therapy sessions. A short course may be appropriate during an acute flare-up; however, this has not been demonstrated nor are there any documented clinical change or functional improvement from treatment rendered previously. Without any new onset or documented plan for a concurrent active exercise program, criteria for massage therapy have not been established per MTUS Chronic Pain Guidelines. The Massage therapy 1x8, lumbar spine is not medically necessary and appropriate.