

Case Number:	CM15-0070651		
Date Assigned:	04/20/2015	Date of Injury:	02/27/2012
Decision Date:	05/20/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/14/2015

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, who sustained an industrial/work injury on 2/27/12. She reported initial complaints of back pain. The injured worker was diagnosed as having lumbosacral neuritis and radiculopathy, chronic pain, s/p lumbar fusion, right sacroiliac joint dysfunction, lumbar facet arthropathy, lumbar myofascial strain, and lumbago. Treatment to date has included medication, diagnostics, surgery (lumbar fusion 1/24/13), activity modification, steroid epidural injection, chiropractic therapy, and injection and nerve block. MRI results were reported on 10/22/09 and 12/19/08. CT Scan results were reported on 3/27/14. Electro-myography and nerve conduction velocity test (EMG/NCV) were performed on 8/20/14. Currently, the injured worker complains of low back pain that was aching and stabbing and rated 8/10. The pain radiated into the right lower extremity to the knee. Per the primary physician's progress report (PR-2) on 2/9/15, examination noted slow gait that was guarded and antalgic. There is tenderness to palpation to the midline of the lumbar spine at the L4-L5 level. Sensation was diminished in the right L4-S1 dermatomes. Reflexes were diminished to the right knee. Straight leg raise was positive on the right. Slump test was positive bilaterally. Current plan of care included pain management and functional capacity testing, and medication. The requested treatments include Prednisone.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Massage Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Massage Therapy.

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

Decision rationale: The patient presents with constant low back pain that radiates down the right lower extremity, rated a 6/10. The request is for 8 MASSAGE THERAPY VISITS. There is no RFA provided and the patient's date of injury is 02/27/12. The diagnoses include lumbosacral neuritis and radiculopathy, chronic pain, s/p lumbar fusion, right sacroiliac joint dysfunction, lumbar facet arthropathy, lumbar myofascial strain, and lumbago. Per 02/09/15 report, physical examination revealed tenderness to palpation in the midline of the lumbar spine at the L4, L5 level. There is decreased range of motion, especially on extension, 0 degrees. The patient's gait is slow, guarded and antalgic and is unable to perform heel or toe walk. Treatment to date has included medication, diagnostics, surgery (lumbar fusion 1/24/13), activity modification, steroid epidural injection, chiropractic therapy, and injection and nerve block. MRI results were reported on 10/22/09 and 12/19/08. CT Scan results were reported on 3/27/14. Electromyography and nerve conduction velocity test (EMG/NCV) were performed on 8/20/14. Current medications are Pamelor and over the counter Aleve. The patient is permanent and stationary. The MTUS Guidelines page 60 on massage therapy states that it is recommended as an option and as an adjunct with other recommended treatments such as exercise and should be limited to 4 to 6 visits. Massage is a passive intervention and treatment, dependence should be avoided. Treater has not provided a reason for the request. There is no indication of prior massage therapy for this patient and given the diagnoses, a trial of 6 treatment sessions would be supported by MTUS. However, the request for 8 sessions of massage therapy would exceed what is recommended by MTUS. Therefore, the request IS NOT medically necessary.