MAXIMUS Federal Services

Case Number:	CM13-0033803		
Date Assigned:	12/06/2013	Date of Injury:	05/02/1999
Decision Date:	02/26/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine 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 physician 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:

Claimant is a 59 year old female with date of injury 5/2/1999. A progress note dated 8/19/2013 reports that the claimant has discomfort in her low back, and some lower extremity issues not related to her back. On exam she has some muscle spasms, normal sensation, and no obvious weakness. Her range of motion is good in the hips and lower extremities. Her low back discomfort is permanent and stationary, but she has had a little bit of a flare-up of some of her muscle strain and low back issues. The provider suggests three visits of myofascial release to train her on stretching and myofascial release techniques that she can do at home. In addition, the provider requests six visit of physical therapy and a lumbar epidural steroid injection. Clinical documentation dated 11/11/2013 reports the claimant's presentation has not changed, and that she would benefit from myofascial release more than physical therapy because she does exercises at home. On exam she has increasing lumbar radicular-like symptoms with straight leg raise and quite a lot of back discomfort.

IMR ISSUES, DECISIONS AND RATIONALES

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

A course of myofascial release x3 visits for the low back: Overturned

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

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

Decision rationale: The Physician Reviewer's decision rationale: Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. Â§Â§9792.20 - 9792.26, massage therapy is "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. Scientific studies show contradictory results. Furthermore, many studies lack long-term followup. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psychologic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007)" The treating provider explains that the claimant would benefit from myofascial release over physical therapy as she is already exercising at home. The additional stretches and myofascial release techniques she is encouraged to learn from these sessions could add benefit to her current back maintenance program. The treating provider is requesting a short course of this passive therapy modality which is supported by these guidelines. The request for myofascial release x3 sessions is therefore determined to be

Physical therapy x6 visits for the low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98-99.

Decision rationale: The Physician Reviewer's decision rationale: Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. Â§Â§9792.20 - 9792.26, physical therapy is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy 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. Active therapy requires an internal effort by the

individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)" Although active therapy is preferred to passive therapy, the requesting provider states that the claimant already has an exercise program and that myofascial release sessions are preferred to physical therapy at this time. The date of injury is over 14 years ago, so it is likely that she has had substantial physical therapy and is already educated on exercises to rehabilitate her injury. The provider states that the claimant currently has muscle spasms that would benefit from myofascial release more than additional physical therapy. The request for physical therapy is therefore determined to not be medically necessary.

Lumbar epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections section Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections section Page(s): 46.

Decision rationale: The Physician Reviewer's decision rationale: Per the Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. Â§Â§9792.20 - 9792.26, epidural steroid injections are: Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain.

(Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchik