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| Case Number: | CM13-0036013 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 04/01/2013 |
| Decision Date: | 02/07/2014 | UR Denial Date: | 09/27/2013 |
| Priority: | Standard | Application Received: | 10/17/2013 |

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 Pain Management, has a subspecialty in Disability Evaluation 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:

The patient is a 45 years old female with stated date of injury of April 1, 2013. She was involved in a motor vehicle accident. She had bruising on her right hip and right foot. She did not feel immediate pain, however, that evening she noted stiffness and soreness in her low back, right hip and right foot. She took some Aleve that night and the next morning, she was awakened by pain in her low back radiating to her mid back and right hip, as well as right foot pain. She contacted her personal physician and was referred for chiropractic treatment with [REDACTED], and at the same time a Workers' Compensation claim was filed. Medication was rendered on a private basis and she began attended chiropractic treatment. She continues to receive the chiropractic treatment to the present date, which she felt was beneficial at first but not later. About one week after the accident, the patient states the symptoms in her right ankle/foot improved. On May 14, 2013, [REDACTED] obtained an MRI of patient's lumbar spine, revealing positive findings, and she was referred to a neurosurgeon. Since about July of 2013, the patient began noting headaches, which she attributes to not sleeping well due to the pain. She has not been treated on an industrial basis for the headaches. Doctor's First Report of Occupational Injury or Illness dated 09/17/13 by [REDACTED], the patient complained of pain of the low back and right hip. Physical examination showed that there was tenderness over the midline in the lumbar spine and over the right greater trochanter in the hip. The patient's weight and height were not documented. The patient was diagnosed with lumbar spine radiculopathy, lumbar spine sprain/strain with underlying disc herniation at L4-L5 and L5-S1 and right hip sprain/strain. Diagnostic imaging and other therapies: According to the nurse summary, the patient had 6 authorized physical therapy sessions and 12 authorized massage therapy sessions, results were not d

IMR ISSUES, DECISIONS AND RATIONALES

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

Therapeutic massage 2 x 3 to the lumbar spine: Upheld

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

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

Decision rationale: CA-MTUS(Effective July 18, 2009) page 60, section on Massage therapy sets as follows: 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 follow-up. 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 psychological 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) In the progress note dated 10/9/2013, the treating physician noted as follows: "The patient has started to see some benefit from the physical therapy and therapeutic massage she has been receiving so therefore, I am going to request authorization for additional treatment. I am going to request authorization for an additional twelve sessions of physical therapy for her lumbar spine and right hip, and I am going to request authorization for six more sessions of therapeutic massage for her lumbar spine. The guideline recommended only 4-6 visits for Massage therapy, therefore the request for additional 6 more sessions of Massage therapy is not medically necessary.