

Case Number:	CM14-0124075		
Date Assigned:	08/13/2014	Date of Injury:	07/25/1985
Decision Date:	09/18/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/05/2014

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. The expert reviewer is Board Certified in Family 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 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/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:

This is an 81 year old female who reported an industrial injury on 7/25/1985, over 19 years ago, attributed to the performance of her customary job tasks. The patient was being treated for the diagnoses of neck pain, cervical spondylosis, degenerative disc disease of the cervical spine, occipital neuralgia, low back pain, lumbar spine degenerative disc disease, status post lumbar fusion, failed back syndrome; plantar fasciitis right, lumbar radiculitis, and chronic opioid use. The patient received treatment with medications; physical therapy; trigger point injections; massage therapy; Percocet to-three per day; Valium PRN; medical marijuana. The patient continued to complain of neck pain; low back pain; bilateral upper shoulder pain; bilateral posterior arm pain; pain to the bottom of her left foot; and left ankle pain. The objective findings on examination included 4/5 reduce muscle strength in all muscles; sensation and reflexes intact; tenderness to palpation over the cervical facet joints and upper trapezius area; limited cervical spine range of motion; tenderness to palpation to the left foot over the plantar fascia. The treatment plan included home health services five days a week for six hours a day; massage therapy with myofascial release (Rolfing); additional physical therapy; and Valium 5 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

In Home Service Care, Five (5) Days/Week, Six (6) Hours/DaY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 91,Chronic Pain Treatment Guidelines home health services Page(s): 51. Decision based on Non-MTUS Citation Medicare guidelines--Centers for Medicare & Medicare Services (CMS). Medicare and Home Health Care. 2004.

Decision rationale: The patient was not documented to have met the criteria recommended for the authorization of home healthcare. The patient was documented to have chronic neck and back pain along with upper extremity pain, however, had the ability to walk without a Walker and have functional range of motion. The provision of home healthcare is for patients who are homebound. The California MTUS recommend home healthcare for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care even by home health aides like bathing, dressing, and using the bathroom when this is the only care required. The patient was documented to have received a months' worth of home health services, however, there was no demonstrated functional improvement and no assessment to support medical necessity. The patient is not documented with the criteria recommended by evidence based guidelines for the provision of home health services due to the reported chronic pain issues. There is no medical necessity for home healthcare services five days a week, six days a week, for an unspecified period of time. The provider did not provide a rationale to support the medical necessity of the requested service. There is no documentation of a disability to the extent where the patient qualifies for home health care for chronic pain issues. There is no objective evidence to support the medical necessity of a home health care on an industrial basis due to the diagnoses or the objective findings on examination. The treating physician has not provided any clinical documentation to support the medical necessity of the requested 30 hours of home healthcare services for this patient directed to the effects of the industrial injury. Therefore, In Home Service Care, Five (5) Days/Week, Six (6) Hours/Days is not medically necessary.

Rolfing Every Week For Twelve (12) Weeks (Per Prescription 07/16/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181,Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back Chapter--massage; Neck and upper back chapter--massage.

Decision rationale: There is no objective evidence provided to support the medical necessity of massage therapy (Rolfing) for the treatment of the effects of the industrial injury directed to mechanical back and neck pain. There are no recommendations of massage therapy for maintenance treatment. There are no recommendations by the MTUS for massage therapy directed to chronic low back pain or neck pain as a stand-alone treatment. The use of massage is usually provided with sessions of PT which the patient has previously utilized. The patient should be in a self-directed home exercise program for strengthening and conditioning. There is

no demonstrated medical necessity for the requested massage therapy 19 years after the DOI. The treatment request by provided no additional objective evidence to support the medical necessity of the requested massage therapy for treatment of mechanical low back pain or lumbar DDD or chronic neck pain with cervical spine DDD. The treating physician did not cite the MTUS or the ACEOM guidelines and did not meet the recommended criteria for authorization with documented objective findings or a demonstrated ongoing functional rehabilitation program. The MTUS chronic pain treatment guidelines only recommend up to 4-6 sessions of massage therapy for an injury and only in conjunction with a rehabilitation exercise program while warning of dependency on passive treatment modalities. There is no demonstrated functional improvement with massage therapy and there is no demonstrated medical necessity for massage therapy as opposed to HEP. The treating physician did not provide subjective/objective evidence to support the medical necessity of the additional physical therapy or additional massage therapy for the treatment of the patient's lumbar spine chronic pain issues over the recommended participation in a self-directed home exercise program. There is no provided medical necessity for the passive treatment with massage therapy over a self-directed home exerciser program. The use of massage therapy for chronic lower back pain and chronic neck pain is not consistent with the recommendations of evidence based guidelines. There is no documentation that massage therapy is being used as an adjunct to a comprehensive rehabilitation plan with strengthening and conditioning. The request for massage therapy was not supported with any clinical rationale from physician for the treatment of the lower back chronic pain issues with more massage therapy. There was no provided objective evidence to support the medical necessity of additional sessions of PT or massage therapy beyond the recommendations of the evidence based guidelines. The patient should be placed on active participation in an independently applied home exercise program consisting of stretching, strengthening and range of motion exercises as opposed to the use of passive massage therapy. There is no subjective/objective evidence provided to support the request for authorization of a referral to massage therapy for 1x12 sessions. Massage Therapy is not recommended for maintenance care of the back/neck chronic pain and is not recommended in place of the home exercise program subsequent to the provided sessions of physical therapy. The passive treatment modality is not recommended for the treatment of chronic back pain in favor of more active participatory exercise programs. The request is inconsistent with the recommendations of the MTUS; the ACOEM Guidelines; and the Official Disability Guidelines for the treatment of chronic pain. There is no objective evidence that the patient is participating in a self directed aerobic exercise program or that massage is an adjunct to a specific protocol for back rehabilitation. The use of massage therapy has some support in evidence based guidelines such as the ODG for the treatment of acute back pain; however it is not recommended for the treatment of chronic back pain. There is no objective evidence that the patient is participating in a self directed home exercise program for functional improvement with conditioning and strengthening. Such as, Roling Every Week for Twelve (12) Weeks (Per Prescription 07/16/14) is not medically necessary.

Rolting Every Two (2) Months For Six (6) Months (Per Report 07/16/14):: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181, Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back Chapter--massage; Neck and upper back chapter--massage.

Decision rationale: There is no objective evidence provided to support the medical necessity of massage therapy (Rolfing) for the treatment of the effects of the industrial injury directed to mechanical back and neck pain. There are no recommendations of massage therapy for maintenance treatment. There are no recommendations by the MTUS for massage therapy directed to chronic low back pain or neck pain as a stand-alone treatment. The use of massage is usually provided with sessions of PT which the patient has previously utilized. The patient should be in a self-directed home exercise program for strengthening and conditioning. There is no demonstrated medical necessity for the requested massage therapy 19 years after the DOI. The treatment request by provided no additional objective evidence to support the medical necessity of the requested massage therapy for treatment of mechanical low back pain or lumbar DDD or chronic neck pain with cervical spine DDD. The treating physician did not cite the MTUS or the ACEOM guidelines and did not meet the recommended criteria for authorization with documented objective findings or a demonstrated ongoing functional rehabilitation program. The MTUS chronic pain treatment guidelines only recommend up to 4-6 sessions of massage therapy for an injury and only in conjunction with a rehabilitation exercise program while warning of dependency on passive treatment modalities. There is no demonstrated functional improvement with massage therapy and there is no demonstrated medical necessity for massage therapy as opposed to HEP. The treating physician did not provide subjective/objective evidence to support the medical necessity of the additional physical therapy or additional massage therapy for the treatment of the patient's lumbar spine chronic pain issues over the recommended participation in a self-directed home exercise program. There is no provided medical necessity for the passive treatment with massage therapy over a self-directed home exerciser program. The use of massage therapy for chronic lower back pain and chronic neck pain is not consistent with the recommendations of evidence based guidelines. There is no documentation that massage therapy is being used as an adjunct to a comprehensive rehabilitation plan with strengthening and conditioning. The request for massage therapy was not supported with any clinical rationale from physician for the treatment of the lower back chronic pain issues with more massage therapy. There was no provided objective evidence to support the medical necessity of additional sessions of PT or massage therapy beyond the recommendations of the evidence based guidelines. The patient should be placed on active participation in an independently applied home exercise program consisting of stretching, strengthening and range of motion exercises as opposed to the use of passive massage therapy. There is no subjective/objective evidence provided to support the request for authorization of a referral to massage therapy for every two months for six months sessions. Massage Therapy is not recommended for maintenance care of the back/neck chronic pain and is not recommended in place of the home exercise program subsequent to the provided sessions of physical therapy. The passive treatment modality is not recommended for the treatment of chronic back pain in favor of more active participatory exercise programs. The request is inconsistent with the recommendations of the MTUS; the ACOEM Guidelines; and the Official Disability Guidelines for the treatment of chronic pain. There is no objective evidence that the patient is participating in a self-directed aerobic exercise program or that massage is an adjunct to a specific protocol for

back rehabilitation. The use of massage therapy has some support in evidence-based guidelines, such as, the ODG for the treatment of acute back pain; however, it is not recommended for the treatment of chronic back pain. There is no objective evidence that the patient is participating in a self-directed home exercise program for functional improvement with conditioning and strengthening. Such as, Roling Every Two (2) Months for Six (6) Months (Per Report 07/16/14): is not medically necessary.

Physical Therapy Evaluate And Treat; Two (2) To Three Times A Week For Eight (8) Weeks And Two (2) To Three (3) Times A Week For Twelve (12) Weeks; Determination Date 07/23/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines physical medicine Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT.

Decision rationale: The request is for authorization of Physical Therapy Evaluate And Treat; Two (2) To Three Times A Week For Eight (8) Weeks And Two (2) To Three (3) Times A Week For Twelve (12) Weeks to the neck, shoulder and back 19 years after the DOI exceeds the number of sessions of PT recommended by the MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy 19 years after the cited DOI with no documented weakness or muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of Physical Therapy Evaluate And Treat; Two (2) To Three Times A Week For Eight (8) Weeks And Two (2) To Three (3) Times A Week For Twelve (12) Weeks to the neck, shoulder and back for the rehabilitation of the patient over the number recommended by evidence based guidelines. The patient is documented with no signs of weakness, no significant reduction of ROM, or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the neck and back 19 years after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested sessions of PT over a self-directed home exercise program as recommended for further conditioning and strengthening. The MTUS recommend up to nine-ten (9-10) sessions of physical therapy over 8 weeks for the shoulder for sprain/strains. The MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar/cervical spine rehabilitation subsequent to lumbar/cervical strain/sprain with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence based guidelines. The current prescription for additional physical therapy represents maintenance care. Such as, Physical Therapy Evaluate And Treat; Two (2) To Three Times A Week For Eight (8) Weeks And Two (2) To Three (3) Times A Week For Twelve (12) Weeks; Determination Date 07/23/2014 is not medically necessary.

Valium 5mg, 1/2 tablet daily, as needed, #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-- medications for chronic pain; benzodiazepines.

Decision rationale: The prescription of Valium for the treatment of insomnia and anxiety is inconsistent with the recommendations of the MTUS, ACOEM Guidelines, and the Official Disability Guidelines. The use of Valium is associated with abuse, dependence; significant side effects related to the psychotropic properties of the medication and are not recommended by the MTUS. The prescription of Valium for sleep or anxiety is not recommended due to the potential for abuse and the long half life of the medication. Alternative medications are readily available for insomnia. The treatment of insomnia is not documented by the provider. No over the counter or other remedies were prescribed prior to prescribing a benzodiazepine. There is no documented alternative treatment with diet and exercise or evaluation of sleep hygiene. The prescription of Diazepam/Valium for this patient is not recommended due to the potential for abuse and the 24 hour half life of the medication. Alternative medications are readily available. There is no clinical documentation with objective findings on examination to support the medical necessity of Diazepam. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Diazepam. There is no demonstrated medical necessity for the prescribed Valium. Therefore, Valium 5mg #30 is not medically necessary.