

Case Number:	CM14-0063797		
Date Assigned:	07/11/2014	Date of Injury:	01/23/2014
Decision Date:	09/30/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/06/2014

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 a 39-year-old male patient to report an industrial injury on 1/23/2014, eight (8) months ago, to the lower back attributed to the performance of his customary work tasks. The patient complained of lower back pain radiating to the lower extremity. The patient was noted to have received chiropractic care/CMT and massage therapy twice a week. The patient had eight (8) prior sessions directed to the lower back with some relief. The patient reported continued stiffness and soreness the right lower back which radiated to the thigh. The objective findings on examination included decreased sensation to the right thumb and index finger. There were no objective findings documented for the lower back. The diagnosis was musculoligamentous strain of the lumbar spine with lower extremity radiculitis. The treatment plan included physical therapy sessions to the right wrist and thumb; massage therapy for the back; chiropractic therapy for the back; (electromyography) (nerve conduction study), EMG/NCS of the upper extremities; and prescribed medications. The patient was continued total temporary disability (TTD).

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy 2 times a week for 4 weeks #8 for the back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability guidelines.

MAXIMUS guideline: Decision based on MTUS 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; American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 8/8/08 chronic pain chapter pages 180-81.

Decision rationale: There is no objective evidence provided to support the medical necessity of massage therapy for the treatment of the effects of the industrial injury directed to mechanical back pain. The patient is documented to have received eight (8) sessions of massage therapy and chiropractic care directed to the lower back for the diagnosis of a musculoligamentous strain. There are no recommendations of massage therapy for maintenance treatment. There are no recommendations by the CA MTUS for massage therapy directed to chronic low back pain as a stand-alone treatment. The use of massage is usually provided with sessions of physical therapy (PT), which the patient has previously utilized. The patient should be in a self-directed home exercise program for strengthening and conditioning. 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. The treating physician did not cite the CA 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 CA 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 home exercise program (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 exercise 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 CA 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. The request for authorization of 2x4 additional sessions of massage therapy directed to the lower back is not demonstrated to be medically necessary.