

Case Number:	CM15-0193016		
Date Assigned:	10/07/2015	Date of Injury:	03/24/2010
Decision Date:	11/20/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/01/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 67-year-old female sustained an industrial injury on 3-24-10. Documentation indicated that the injured worker was receiving treatment for displacement of lumbar intervertebral disc, lumbago, lumbar stenosis and sacroiliitis. In a progress report dated 2-9-15, the injured worker complained of pain rated 5 out of 10 on the visual analog scale. The injured worker was not working. The injured worker was playing golf. The injured worker reported getting good pain relief for a few days with massage. Physical exam was remarkable for lumbar spine with "normal" range of motion, negative straight leg raise and normal gait. In a progress note dated 6-15-15, the injured worker complained of low back pain rated 5 out of 10. The injured worker reported that she had not had massage therapy since October 2014. The injured worker was not able to exercise due to low back pain. The injured worker tried to play golf but it was difficult to due pain. Vacuuming and mopping exacerbated her pain. In a progress report dated 9-14-15, the injured worker complained of low back pain, rated 5 out of 10 on the visual analog scale associated with left foot and calf cramping at night. The injured worker was using a self-purchased massager and Ibuprofen for pain relief. The injured worker reported that previous massage and physical therapy with traction provided great relief. Physical exam was remarkable for lumbar spine with loss of normal lordosis, "restricted" range of motion secondary to pain and tenderness to palpation to the paraspinal musculature with negative straight leg raise. The injured worker walked with an antalgic gait. The treatment plan included magnetic resonance imaging lumbar spine without contrast, massage therapy once a week for twelve weeks and physical therapy with traction twice a week for twelve weeks. On 9-21-15, Utilization Review non-certified a request for magnetic resonance imaging lumbar spine without contrast, massage therapy once a week for twelve weeks and physical therapy with traction twice a week for twelve weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, MRI.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria.

Decision rationale: Notes that unequivocal objective findings that indentify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in injured workers who do not respond to treatment and who would consider surgery and option. When the neurological examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. According to ODG, Low Back Procedure Summary, Indications for MRI: Thoracic spine trauma with neurological deficit; Lumbar spine trauma with neurological deficit; Lumbar spine trauma, seat belt (chance) fracture (if focal , radicular findings or other neurologic deficit) Uncomplicated low back pain: suspicions of cancer, infection or other red flags; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurologic deficit related to spinal cord), traumatic Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease injured worker; Myelopathy, oncology injured worker. According to the documents available for review, the injured worker exhibits none of the aforementioned indications for lumbar MRI nor does he have a physical exam, which would warrant the necessity of an MRI. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

Massage Therapy, once a week for twelve weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

Decision rationale: 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 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 injured workers and be able to refer injured workers to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in injured workers who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007) According to the documents available for review, the IW previously underwent several sessions of manual therapy without documented functional improvement. Therefore, at this time, the requirements for treatment have not been met, and medical necessity has not been established.

Physical Therapy with traction two per week for twelve weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the injured worker) 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). Injured workers 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) Injured worker-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 injured workers 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) Physical Medicine Guidelines; Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. According to the documents available for review, the injured worker has previously undergone numerous session of PT without objective documented functional improvement. Further sessions of PT would be in contrast to the guidelines as set forth in the MTUS. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.