MAXIMUS Federal Services

Case Number:	CM15-0224869		
Date Assigned:	11/23/2015	Date of Injury:	06/04/2010
Decision Date:	12/31/2015	UR Denial Date:	11/12/2015
Priority:	Standard	Application Received:	11/16/2015

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: California, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 42 year old female, who sustained an industrial injury on 6-4-2010. The injured worker is undergoing treatment for: pain to the neck, upper back, left shoulder, left elbow, bilateral wrists, and bilateral thumbs. The treatment and diagnostic testing to date has included: medications, MRI of the left shoulder and right thumb (date unclear), x-rays of the neck, left shoulder, and bilateral wrists (date unclear), at least 18 sessions of physical and occupational therapy, at least 4 sessions of chiropractic therapy, home exercise program, multiple cervical spine epidural steroid injections (dates unclear), steroid injections to shoulder and wrists (dates unclear). Medications have included: Norco, Nabumetone, Tramadol, Mobic, Celebrex, Naproxen, Lidoderm patches, voltaren, and omeprazole. On 10-14-15, she reported pain to the neck, upper back, left shoulder, left elbow, bilateral wrists, and bilateral thumbs with associated weakness of the left arm. She rated her pain 5 out of 10. Objective findings revealed trigger point with radiating pain and twitch response noted on palpation of cervical paraspinal muscles bilaterally, increased muscle tone of trapezii, tenderness in the neck, trail's sign negative, wadell's sign negative, slow ambulatory gait, tenderness in the neck, decreased neck range of motion, tenderness in the left shoulder, positive testing for hawkin's, crossed arm and left off, negative drop arm testing, decreased deep tendon reflexes in biceps, brachioradialis, triceps, patella and ankles, left shoulder strength weakness. Current work status: full time. The request for authorization is for: 8 visits of massage therapy, and trigger point injections for the left shoulder. The UR dated 11-12-2015: non-certified the request for 8 visits of massage therapy, and trigger point injections for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy, quantity: 8 sessions: 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: CA MTUS Chronic Pain Medical Treatment Guidelines, page 60, discusses the indications for massage therapy. 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 could 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) In this case, the clinical note from 10/14/15 requests 8 massage treatments. This exceeds the number of visits per CA MTUS guidelines. Based on the MTUS guidelines the 8 requested massage therapy appointments are not medically necessary.

Trigger point injections for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Trigger point injections, page 122 defines a trigger point as "a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific

trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination." The guidelines continue to define the indications for trigger point injections, which are as follows: "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain or fibromyalgia. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended." CA MTUS guidelines state that trigger point injections are not indicated for radicular pain, fibromyalgia, typical back pain or typical neck pain. In this case, the exam notes from 10/14/15 demonstrate no evidence of myofascial pain syndrome. This patient has typical neck pain. Therefore, the trigger point injection is not medically necessary and the determination is for non-certification.