

Case Number:	CM14-0123654		
Date Assigned:	08/08/2014	Date of Injury:	10/26/1995
Decision Date:	10/08/2014	UR Denial Date:	07/22/2014
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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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:

The injured worker is a 60-year-old female who reported an injury on 10/26/1995. She sustained injuries to her lower back when the injured worker slipped and fell on a wet surface. The injured worker was evaluated on 08/06/2014. It is documented the injured worker complained of ongoing low back pain. She rated her pain at 8/10 on the pain scale. The injured worker continued her current medications, to include Protonix, Flexeril, Ambien, tramadol, gabapentin, naproxen, and Cymbalta. The provider noted the injured worker was recently denied massage, heat and ice therapy. The provider noted this would be appealed. Objective findings included blood pressure 150/86, pulse 88, respiratory 20, temperature 98.6. Upon assessment, she continued to have tenderness upon palpation over the lower sacral area. When she hyper extends her back, she felt an increased pain that radiated down her left thigh to her calf. When she was able to forward flex, touching the ground, she can do lateral flexion to about 45 degrees, otherwise lower extremities are intact. Diagnoses included a lumbar myofascial pain, lumbar radiculitis, intervertebral disc disease, cervical myofascial pain, cervical radiculitis, and trigger thumbs bilaterally. Request for Authorization dated 08/06/2014 was for massage therapy, ice/heat, and electrical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage Therapy 2 X 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Massage Therapy Page(s): Page: 60.

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

Decision rationale: The request for massage therapy 2 X 6 is not medically necessary. California (MTUS) Chronic Pain Medical Guidelines recommends massage therapy as an option. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 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. The documents submitted on 08/06/2014 failed to indicate if the injured worker had prior conservative care. However, outcome measurements were not provided. The request failed to include where massage therapy is required. Therefore, the request is not medically necessary.

Ice/ Heat 2 X 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines 9ODG): Low Back; Neck & Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The request for Ice/Heat 2X6 is not medically necessary. Per CA MTUS/ACEOM guidelines recommends comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and sub acute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences guide the clinician's choice of recommendations. It also states physical methods for low back are as follows; Adjustment or modification of workstation, job tasks, or work hours and methods; Stretching; At-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold; Relaxation techniques; Aerobic exercise; 1-2 visits for education, counseling, and evaluation of home exercise for range of motion and strengthening. The guidelines recommend Ice the first few days after the acute complaint. Duration of pain and onset symptoms could not be established. Additionally, the request failed to indicate where Ice/Heat treatment is required. As such, the request is not medically necessary.

Electrical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): Pages: 114, 116, 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS. Page(s): 114-116.

Decision rationale: The requested is not medically necessary. Chronic Pain Medical Treatment Guidelines does not recommend a tens unit as a primary treatment modality, but a one-month home-based Tens trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration and other ongoing pain treatment including medication usage. It also states that the tens unit is recommended for neuropathic pain including diabetic neuropathy and post-herpetic neuralgia. The guidelines recommends as a treatment option for acute post-operative pain in the first thirty days post-surgery. The provider failed to indicate long- term functional restoration goals for the injured worker. The provider failed to indicate prior conservative treatment such as physical therapy outcome measurements. Additionally, the request failed to indicate frequency and location where the Tens unit should be used on the injured worker. Given the above, the request for transcutaneous electrical nerve stimulation (TENS) unit is not medically necessary.