

Case Number:	CM15-0015316		
Date Assigned:	02/03/2015	Date of Injury:	06/23/2010
Decision Date:	03/24/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	01/27/2015

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

Certification(s)/Specialty: Family Practice

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 57 year old female, who sustained an industrial injury on June 23, 2013. The diagnoses have included bulge and possible herniation of the lumbosacral spine. Treatment to date has included physical therapy, home exercise, chiropractic therapy, medications, acupuncture and TENS unit. Currently, the injured worker complains of increased pain to the low back and legs. The injured worker rated the pain a 2 on a 10-point scale when at rest and a 4-5/10 with movement. On exam, the injured worker had mild-moderate tenderness over the lower lumbar spine. A straight leg raise was negative and her circulation and sensation were intact. On January 26, 2015 Utilization Review modified/non-certified a request for chiropractic treatments to the low back, massage, mechanical traction and electrical stimulation, noting that there is no specific functional loss or objective functional treatment goals documented from chiropractic therapy. The California Medical Treatment Utilization Schedule was cited. On January 27, 2015, the injured worker submitted an application for IMR for review of chiropractic treatments to the low back, massage, mechanical traction and electrical stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments to the low back for a flare-up QTY 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58 and 59.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of manual therapy and manipulation, such as chiropractic care, as a treatment modality. These guidelines state the following: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks; Elective/maintenance care not medically necessary. Recurrences/flare-ups need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. Injured workers with complicating factors may need more treatment, if documented by the treating physician. Number of Visits: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. In this case, the records indicate that the patient has previously undergone an unspecified number of chiropractic treatments. There is insufficient documentation as to objective evidence of functional improvement and outcomes such as reduction in pain severity based on these prior treatments. Further, the above stated guidelines specifically for flare-ups, recommended treatment are 1-2 visits every 4-6 months. For these reasons, chiropractic treatments to the low back for a flare-up x 6 sessions are not considered as medically necessary.

Massage QTY 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of massage therapy as a treatment modality. These guidelines state the following: 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. 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. 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. 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. In this case, the records suggest the patient has had a prior course of massage therapy. It is unclear how many sessions were included in prior massage therapy sessions. Further, there is insufficient documentation on functional outcomes from these sessions. Further, there is insufficient documentation as to whether massage therapy is being used as an adjunct to other interventions, for example an exercise program, as indicated in the above cited guidelines. For these reasons, massage therapy x 6 sessions is not considered as a medically necessary intervention.

Mechanical Traction QTY 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Complaints.

Decision rationale: The Official Disability Guidelines comment on the use of traction as a treatment modality for patients with low back complaints. These guidelines state the following: Not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. Traction is the

use of force that separates the joint surfaces and elongates the surrounding soft tissues. The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica. In this case, the Official Disability Guidelines do not support the use of traction as a treatment modality. While it is not clear what type of traction device is being requested, the ODG are not in support of this form of treatment. For this reason, mechanical traction x 6 is not considered as a medically necessary intervention.

Electrical stimulation QTY 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Stimulation Page(s): 114-121.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of electrical stimulation as a treatment modality. While there are many different types of electrical stimulation available, and it is not specified in this request, the most common type used in practice is TENS (transcutaneous electrical stimulation). The MTUS guidelines provide criteria for the use of TENS. These are as follow: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration - There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. In this case it is unclear which type of electrical stimulation is being requested. The patient does not meet the MTUS guideline criteria for the use of TENS. Specifically, there is insufficient evidence of a one-month trial and of efforts to monitor objective functional outcomes. For these reasons, electrical stimulation x 6 is not considered as medically necessary.