MAXIMUS Federal Services

Case Number:	CM15-0176046		
Date Assigned:	09/17/2015	Date of Injury:	07/21/2008
Decision Date:	10/20/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/08/2015

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: North Carolina
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 (IW) is a 67-year-old male who sustained an industrial injury on 07/21/2008. He was diagnosed as having lumbar sprain and multi-level spondylosis with disc extrusions. Treatment to date has included transforaminal epidural injections (TFESI) (04-07-2015), massage therapy, Chiropractic treatments, and medications including Hydrocodone-Acetaminophen 10-325 tablets, Lyrica, and Ibuprofen. In the provider notes of 06-09-2015, the injured worker relates that his pain has improved since the TFESI of 04-07-2015 but it was not as effective as some of the previous ones. His pain level is a 9 on a scale of 0-10, and is worse with bending and extension. He has lower extremity radiation of pain left more than right, and some right-sided weakness when he increases his activity. On exam, he has a 10-degree forward flexing posture, slight tenderness over his lumbar spine, and is able to bend forward and touch his knees with increasing back pain and pulling down the left. Hip flexion is 90 degrees sitting. Sitting straight leg raising is equivocally positive versus hamstring tightness. Knee extension is 0 degrees with 90 degrees flexion. Manual muscle testing is 5 of 5 in the hip flexors, flexor extensors, and foot ankle flexor extensions. The treatment plans are to trial massage therapy, consider chiropractic therapy, and renew prescriptions of Ibuprofen, Hydrocodone-Acetaminophen 10-325 tablets, trial Flexeril 10 mg, and have massage therapy to increase range of motion and reduce stiffness. On 08-13-2015, the IW has had four chiropractic treatments, and felt they were helpful. His lumbar flexion is 75 degrees, extension is 15 degrees, left rotation is 20 degrees, right rotation 25 degrees, and both left and right lateral flexion is 15 degrees. All movements have complaint of low back pain with examination revealing pain, tenderness and

spasm. On 08-11-2015, the worker is seen in follow-up. His pain ranges 6-9 located centrally with lower extremity aching and some weakness with prolonged standing and walking. He has completed 4 sessions of massage therapy and his pain score has decreased from 10 on a scale of 10 to a 7 on a scale of 10. He continues with tenderness over the left lumbar spine and has a slight increase in forward flexion, now being able to touch his proximal tibia. He can extend 10 degrees with endpoint discomfort. Sitting straight leg raise on both sides is 90 degrees without gross pulling .Foot plantar flexion, dorsiflexion and knee range of motion is 100 percent. The plan of care is for pain management follow-up and additional massage and Chiropractic therapy. A request for authorization was submitted for chiropractic therapy, Hip, Lower Back area, Lumbar/Sacral Vertebrae, Multiple Lower Extremities, 1 time wkly for 6 wks., 6 sessions, and Massage therapy, Lumbar/Sacral Vertebrae, 1 time wkly for 6 wks., 6 sessions. A utilization review decision 08-21-2015 non-certified the requests for Chiropractic therapy and Massage therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy, Hip, Lower Back area, Lumbar/Sacral Vertebrae, Multiple Lower Extremities, 1 time wkly for 6 wks, 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: 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 reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments Manual manipulation is recommended form of treatment for chronic pain. However, previous sessions have not produced documented significant improvement in pain and function. Therefore, the request is not medically necessary.

Massage therapy, Lumbar/Sacral Vertebrae, 1 time wkly for 6 wks, 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 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) While recommended, previous sessions have not produced documented significant objective improvements in pain and function. Therefore, the request is not medically necessary.