

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

08/16/2010

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical/lumbar massage therapy two to three times per week for six weeks (eighteen visits) 97124.

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified Physical Medicine and Rehabilitation Physician

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**The requested cervical/lumbar massage therapy, two to three times per week for six weeks (eighteen visits) is not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 08/03/10 MCMC Referral
- 08/03/10 letter from Network & Medical Operations, with attached response regarding disputed services
- 08/03/10 Treatment History
- 08/02/10 Notice To MCMC, LLC Of Case Assignment, , DWC
- 07/30/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 07/27/10 Request For A Review By An Independent Review Organization
- 07/01/10 letter from, Review Nurse,
- 06/01/10 Notification of Adverse Determination letter, , D.O., with attached Review Summary
- 04/30/10 (date signed) Outpatient Rehabilitation Center note, Hospital
- 04/08/10 (start of care date) office note, , M.D., Hospital – Outpatient Rehabilitation Center (signed by, PT On 04/12/10)
- 04/08/10 Physical Therapy Treatment Record, Hospital
- 04/07/10 prescription note, Dr. Medical Clinic (with handwritten note dated 04/21/10)
- 02/01/10 letter from, M.D., Medical Clinic
- 12/17/09 to 07/01/10 Progress Notes, , M.D., Medical Clinic
- ODG Integrated Treatment/Disability Duration Guidelines for Neck and Upper Back (Acute & Chronic)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a female with neck and lower back pain being treated by Medical Clinic with original injury date of xx/xx/xx when a co-worker fell on the injured individual spraining her lower back. She underwent surgery and according to her current physician has a failed back syndrome. She later had a cervical discectomy with fusion at C5-6 on 09/19/2007. The injured individual has been treated with Lorcet and Soma. There have been multiple requests for message therapy instead of regular physical therapy (PT) due to her spinal fusion at C5-6. There is presented limited range of motion of the neck with spasms and occasional trigger point problems. The clinical presentation of the injured individual consists of an absence of neurological complaints. Her physician MD felt the injured individual was a candidate for psychological counseling, physical therapy, education and biofeedback and transfer to less opioid based medical therapy as of 03/12/2010. A Physical Therapy review on 04/12/2010 indicated some limited range of motion of the neck and left upper extremity weaker than right upper extremity in general. A recent clinical note by Dr. did not indicate any clinical changes.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The submitted information does not indicate the results of prior physical therapy in an objective form nor does it indicate that massage therapy was used a part of the treatment plan. As such there is no documentation indicating whether there was improvement in range of motion of the neck and back with therapy.

The rationale for massage therapy alone with general exercise in the pool is not explained by the physician. There is no information whether the injured individual is performing a home exercise program. In addition there is no specific data whether the injured individual has improved in function over the last six to twelve months with standard therapy.

Based on the Official Disability Guidelines for the neck and lower back areas, massage is recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional provider has shown some proven efficacy in the treatment of acute low back syndrome. However in this case the condition is chronic not acute (Cherkin 2001), Cherkin – Annals, 2003), Sherman 2004).

There is limited evidence for the effectiveness of massage therapy as add on treatment to manual therapy and manual therapy as add on treatment to exercises (Verhagen, 2006).

Records did not include therapy progress reports to determine whether the injured individual has had sufficient number of therapy and failure/plateau with therapy. Records did not indicate plans for the injured individual's participation in an active, independent exercise regimen that would be continued in conjunction with the proposed massage therapy. There is no documentation of specific time limited functional goals for massage therapy.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:****ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**