

<b>Case Number:</b>	CM13-0042577		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	11/19/2004
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	10/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Physical Medicine and Rehabilitation 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:

This 58 year-old patient sustained an injury on 11/19/04 while employed by [REDACTED]. Request under consideration include Massage therapy twice a week for three weeks for the right lower extremity. The patient has diagnosis of bilateral plantar fasciitis from claimed injury of 2004. Conservative care has included analgesic medications, extensive time off work, and unspecified quantity of massage therapy and physical therapy. Report of 8/21/13 from the provider noted persistent right heel pain with standing and walking; has been using orthotics and medications to control blood pressure; has fair control of blood sugar. Exam noted skin is peeling about the bilateral feet; exhibits decreased sensation (no dermatome identified). It was recommended to consider cortisone injections which the patient has deferred; patient is to continue with home exercises; will request for massage therapy; and the patient remains totally temporarily disabled. Request above for 6 session of massage therapy was non-certified on 10/12/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage therapy twice a week for three weeks for the right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
MASSAGE THERAPY Page(s): 60.

**Decision rationale:** Guidelines indicate that massage is recommended for time-limited use in sub acute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. However, this is not the case for this 2004 injury which is status post unspecified significant conservative massage and physical therapy currently on an independent home exercise program without plan for formal physical therapy sessions. The patient remains on TTD without return to any form of modified work. A short course may be appropriate during an acute flare-up; however, this has not been demonstrated nor are there any documented clinical change or functional improvement from treatment rendered previously. Without any new onset or documented plan for a concurrent active exercise program, criteria for massage therapy have not been established per MTUS Chronic Pain Guidelines. The Massage therapy twice a week for three weeks for the right lower extremity is not medically necessary and appropriate.