

Case Number:	CM14-0098370		
Date Assigned:	07/28/2014	Date of Injury:	05/20/2010
Decision Date:	11/18/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/26/2014

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 Family Medicine and is licensed to practice in Utah. 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 patient is a 58 year-old female. The patient's date of injury is 5/20/2010. The mechanism of injury is described as an injury to the right shoulder. The patient has been diagnosed with headaches, shoulder impingement, labral tear, rotator tendinosis, synovitis, thoracic outlet syndrome, bilateral ulnar compressive neuropathy and a cervical spine injury. The patient's treatments have included previous surgery, physical therapy, and medications. The physical exam findings dated November 27, 2013 states she is slightly obese with no ambulatory aids. There is noted atrophy of both shoulder girdles. The gait is normal. The upper extremity ranges of motion are normal except for the shoulders. There is no spasm noted in the cervical or thoracic region. There is tenderness present in the cervical region of the trapezius bilaterally. There is also tenderness of the supraclavicular regions of both sides. Motor strength is reported as decreased. The patient's medications have included, but are not limited to, Fiorinal, Percocet, Norco, Soma and Ibuprofen. The request is for Massage therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy 16 units 2x8 for the cervical: 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: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Massage Therapy. MTUS guidelines state the following: Massage is recommended as an option. This treatment should be an adjunct to other recommended treatments, (e.g. exercise) and it should be limited to 4-6 visits in most cases. The clinical documents state that the patient was in physical therapy, but the current request exceeds the recommended amount of visits. According to the clinical documentation provided and current MTUS guidelines; massage therapy, as requested above, is not indicated as a medical necessity to the patient at this time.