

Case Number:	CM14-0173661		
Date Assigned:	10/24/2014	Date of Injury:	03/02/2011
Decision Date:	01/30/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/21/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 51 yo female who sustained an industrial injury on 03/02/2011. The mechanism of injury was not provided in the documentation for review. Her diagnoses are cervical spondylosis and arthrosis with spinal and foraminal stenosis; chronic left shoulder pain with arthritis; rotator cuff tears, bicipital tendonitis and labrum degeneration. She continues to complain of neck and left shoulder pain. On physical exam cervical range of motion is full for her age with flexion and extension to 45 degrees and bilateral rotation to 60 degrees. Spurling's test was negative. There was full range of motion of the left shoulder. Strength and sensation are normal. Treatment has included medical therapy and steroid injection therapy. The treating provider has requested massage therapy QTY:8.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy qty: 8: 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: The requested massage therapy is not medically necessary and reasonable per the reviewed guidelines. 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. Massage therapy is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Medical necessity for the requested item has not been established. Per the guidelines, the request should be a maximum of 6 visits only. Therefore, this request is not medically necessary.