

Case Number:	CM14-0206016		
Date Assigned:	01/30/2015	Date of Injury:	10/23/2008
Decision Date:	03/03/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/09/2014

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, the injured worker is a 62 year-old female with a date of injury of 10/23/2008. The results of the injury include the cervical spine, bilateral wrists/hands, right elbow, and low back. Diagnoses have included cervical syndrome with radiculopathy; right elbow sprain; status post right carpal tunnel decompressive surgery, status post left carpal tunnel decompressive surgery, and lumbosacral syndrome with sciatica. Diagnostic studies were not submitted for review. Treatments have included medications, TENS unit, H-wave, cortisone injection to the wrist, chiropractic treatments, physical therapy, and surgical intervention. Medications have included Lisinopril, Metformin, Cymbalta, Soma, and Lidoderm patches. Surgical interventions have included right carpal tunnel decompressive surgery and right third finger release, performed on 04/02/2009, and left carpal tunnel decompressive surgery, performed on 10/06/2009. An Agreed Medical Re-Examination physician's note, dated 06/12/2013, documented a re-examination visit. The injured worker reported constant pain in the cervical spine, which radiates into the bilateral upper extremities; numbness/tingling/weakness in the upper extremities; headaches with nausea and dizziness; neck pain, aggravated by movement of the head and neck, prolonged positioning, using the upper limbs above the shoulder, and heavy lifting/pushing/pulling. The injured worker reports relief from pain with medications, application of heat, and massage. Objective findings included tenderness to palpation at the posterior aspect of the cervical spine, right and left trapezius muscles, and along the vertebral borders of the scapulae; decreased range of motion of the

cervical spine; generalized tenderness to palpation over the right elbow; decreased range of motion and extreme pain with flexion of the right elbow; well-healed incisional scars over the palmar aspects of the right and left wrist; tenderness to palpation over the right and left wrist/hand/thumbs and index fingers; tenderness to palpation in the low back area in the midline, right and left paraspinal musculature, and over the greater sciatic notches and posterior thighs bilaterally. Based on this examination and symptomatology, the physician documented that the injured worker is a candidate for further treatment. Work status is noted as: temporarily total disability. Request is being made for a prescription for Retro Massage Therapy 08/17/12-06/29/13. On 11/17/2014, Utilization Review non-certified a prescription for Retro Massage Therapy 08/17/12-06/29/13. Utilization Review non-certified a prescription for Retro Massage Therapy 08/17/12-06/29/13 based on the lack of documentation for active rehabilitation in conjunction with massage therapy. As well, the total number of treatments was not specified, and massage therapy should be limited to 4-6 visits in most cases. The Utilization Review cited the CA MTUS: Neck and Upper Back Complaints; Low Back Complaints; and Chronic Pain Medical Treatment Guidelines: Massage Therapy. Application for independent medical review was made on 12/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO Massage Therapy 08/17/12-06/29/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Massage Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Pain (Chronic), Massage Therapy, Manual Therapy

Decision rationale: MTUS states regarding massage therapy, 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. ODG offers additional frequency and timeline for massage therapy by recommending: a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. Medical documents do not indicate reasons for treatment in excess of the 8-week maximum. The request is in excess of the guidelines recommendation of 4-6 visits over no more than 8 week. As such, the request for RETRO MASSAGE THERAPY 8/17/12-6/29/13 is not medically necessary.