

Case Number:	CM15-0001774		
Date Assigned:	01/12/2015	Date of Injury:	10/17/2012
Decision Date:	03/06/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/05/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 is a year 44 old male with a date of injury of 10/17/12. He is being treated for shoulder and upper arm sprain and strain and right biceps tear. Subjective findings on 12/18/14 include aching /weakness in biceps after extending arm, working with modified duty. Objective findings include tenderness over right shoulder and latissimus dorsi. EMG and NCV on 11/18/14 was normal. Treatment thus far has consisted of heat, ice, medications (Naprosyn, Tylenol #3, and cyclobenzaprine), physical therapy and massage therapy. The Utilization Review on 12/30/14 found the request for additional massage therapy x 6 visits to the right shoulder to be non-certify due to lack of documented functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional massage therapy x 6 visits to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS 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. The request is in excess of the guidelines recommendation of 4-6 visits over no more than 8 weeks. Medical documents do not indicate reasons for treatment in excess of the 8-week maximum as there is no evidence of functional improvement. As such, the request for additional massage therapy x 6 visits to the right shoulder is not medically necessary at this time.