

<b>Case Number:</b>	CM15-0136568		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	04/17/2009
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 injured worker is a 61 year old female who sustained an industrial injury on 04-17-09. Initial complaints and diagnoses are not available. Treatments to date include medications. Diagnostic studies are not addressed. Current complaints include continued right shoulder pain. Current diagnoses include cervical spine herniated nucleus pulposus, right shoulder impingement, and lateral epicondylitis. In a progress note dated 05-08-15 the treating provider reports the plan of care as chiropractic services, acupuncture, TENS unit, and medications including Soma and Voltaren gel. The requested treatments include massage treatments to the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage therapy 2 times a week for 6 weeks for the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. MTUS (Effective July 18, 2009) Page(s): 60 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Massage Therapy.

**Decision rationale:** Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, if there has been previous massage therapy, there is no documentation as to the number of visits previously provided, or any objective functional improvement as a result of those visits. If no sessions have been provided previously, the currently requested 12 sessions exceeds the number recommended by guidelines. Additionally, there is no indication that the currently requested massage therapy will be used as an adjunct to other recommended treatment modalities. Finally, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested massage therapy. In the absence of clarity regarding those issues, the currently requested massage therapy is not medically necessary.