

<b>Case Number:</b>	CM15-0206186		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	01/04/2001
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 49 year old male, who sustained an industrial injury on 01-04-2001. A review of the medical records indicates that the worker is undergoing treatment for chronic low back pain status post lumbar fusion with subsequent hardware removal, chronic pain syndrome and chronic cervical spine sprain and strain. Subjective complaints (05-21-2015, 07-16-2015 and 09-17-2015) included neck, low back and bilateral shoulder pain rated as 10 out of 10 without medications and 6 out of 10 with medications. Objective findings (05-21-2015, 07-16-2015 and 09-17-2015) included severe pain and spasm in the neck, lumbar spasm and positive straight leg raise to 70 degrees bilaterally. Treatment has included OxyContin, Xanax, Cymbalta, Norco, transcutaneous electrical nerve stimulator unit and massage therapy. The physician noted that massage therapy was helping and that additional massage therapy would be requested, however there was no further information given as to how massage therapy was helping. There was no documentation of the degree of pain relief or any objective functional improvements noted with therapy and it's unclear how many massage therapy visits were received to date. A utilization review dated 10-01-2015 non-certified a request for massage therapy for lumbar spine once every 2 weeks for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage therapy for lumbar spine once every 2 weeks for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Massage therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 09/22/15) - Online Version.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

**Decision rationale:** According to the guidelines, massage therapy is recommended as an option for up to 6 sessions. In this case, the claimant has been undergoing an unknown amount of massage therapy. An additional 6 sessions were requested in July and again in Sept 2015. The massage therapy request exceeds the guidelines amount and is not medically necessary.