

Case Number:	CM15-0216646		
Date Assigned:	11/06/2015	Date of Injury:	06/02/2014
Decision Date:	12/21/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/03/2015

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: New Jersey

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 61 year old male, who sustained an industrial injury on 6-2-14. The injured worker was being treated for degenerative joint disease, disorders of synovium, tendon, bursa, and calcific tendinitis. On 9-29-15, the injured worker complains of right hip pain with no improvement in symptoms and achy right lower back and posterior right hip. Work status is noted to be modified duties. Physical exam performed on 9-29-15 revealed tenderness to palpation of lumbar paraspinals on right, tenderness of right greater trochanter and decreased range of motion of right hip. Treatment to date has included physical therapy, intraarticular corticosteroid injection, home exercise program, modified duties and oral medications including Robaxin and Naproxen. The treatment plan included follow up appointment. On 11-2-15 request for 6 massage therapy myofascial release visits was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage therapy for myofascial release 2x per week for 3 weeks for the right hip: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back and Hip and Pelvis sections, Massage.

Decision rationale: The MTUS Chronic Treatment Guidelines recommend massage therapy (up to 4-6 visits in most cases) as an adjunct to other recommended treatments such as exercise and may be helpful at attenuating diffuse musculoskeletal symptoms as well as anxiety and stress reduction. Passive treatments such as massage can lead to dependence and are not recommended for frequent sessions. Massage may be recommended for acute injuries, chronic pain (if not already trialed), and post-operatively. The ODG states that mechanical massage devices are not recommended. The ODG also allows massage therapy to continue beyond the trial period up to a total of 18 visits over 6-8 weeks with evidence of objective functional improvement. In the case of this worker, there was no record of actively performing (or plans to) home exercises or other physical therapy to match the massage therapy, which is a passive therapy which should not be completed as primary therapy. Therefore, this request for massage therapy for the right hip is not medically necessary.