

<b>Case Number:</b>	CM14-0080739		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	09/17/2012
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 48 year old female who reported an injury on 09/17/2012. The mechanism of injury was a motor vehicle accident. The injured worker had diagnoses including lumbar sprain. Prior treatment included a TENS unit, physical therapy, massage therapy, chiropractic treatment, and acupuncture. Diagnostic studies included an MRI of the lumbar spine and electrodiagnostic studies performed 05/24/2013. The injured worker complained of neck and lower back pain which radiated to the bilateral thighs and right leg. The injured worker rated his pain 8/10 with medications. The clinical note dated 05/02/2014 reported that the injured worker's lumbar spine range of motion was restricted and limited by pain with flexion to 40 degrees and extension to 10 degrees. On palpation, there were paravertebral muscle spasms and tenderness and tight muscle band was noted on both sides. There was tenderness noted over the sacroiliac spine. There was decreased light touch sensation over the medial and lateral calf on the left side. Medications included Cyclobenzaprine, Norco and Quazepam. The treatment plan included a request for Massage therapy to treat the lumbar region. The rationale for the request was not indicated. The request for authorization was not provided within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage therapy to treat the lumbar region:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** The decision for the requested massage therapy, lumbar, is not medically necessary. The injured worker complained of daily headaches and flare-up of pain due to traveling and sitting of prolonged period. The California MTUS guidelines note massage treatment should be used as an adjunct to other treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. There is a lack of documentation provided indicating that this passive modality will be used as an adjunct to facilitate progress to an active form of treatment to improve function. The requesting physician's rationale for the request is not indicated within the provided documentation. Therefore the request for massage therapy two times a week for two weeks, lumbar is not medically necessary.