

<b>Case Number:</b>	CM15-0066618		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	02/01/2001
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/08/2015

### 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

### 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 female, who sustained an industrial injury on 2/1/01. She reported neck pain, upper extremity pain, hand pain, bilateral wrist pain, and right medial elbow pain. The injured worker was diagnosed as having cervical spondylosis without myelopathy and lateral epicondylitis. Treatment to date has included left shoulder surgery, a cervical epidural steroid injection, massage therapy that was noted to be effective, a functional restoration program, and medications. A MRI of the cervical spine performed on 4/21/14 revealed degenerative disc disease at C3-4 and C6-7, central spinal canal narrowing due to disc bulges and facet joint arthropathy from C3-4 and C6-7, disc protrusions at C3-C7, and central disc herniations from C3-6. A MRI of the left shoulder obtained on 2/14/14 revealed postsurgical findings of a rotator cuff repair and tendinosis. Currently, the injured worker complains of neck and right upper extremity pain. The treating physician requested authorization for massage therapy x6. The treating physician noted massage therapy might be beneficial in avoiding increasing medical management and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage therapy qty: 6:** Overturned

**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 patient was injured on 02/01/01 and presents with neck pain and right upper extremity pain. The request is for MASSAGE THERAPY QTY: 6. The utilization review denial rationale is that "there is no objective documentation of pain, tenderness, limited range of motion, muscle tightness, stress, or anxiety." The RFA is dated 02/26/15 and the patient is permanent and stationary. Review of the reports provided does not indicate if the patient had any prior massage therapy sessions. MTUS Chronic Pain Medical Treatment Guidelines, page 60 for Massage therapy states: "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." The reason for the request is not provided and there are no positive exam findings provided. The patient is diagnosed with cervical spondylosis and epicondylitis lateral. Given the patient's chronic neck pain and right upper extremity pain, a trial of six massage therapy sessions appears reasonable. The requested massage therapy IS medically necessary.