

Case Number:	CM14-0118120		
Date Assigned:	09/16/2014	Date of Injury:	02/19/2012
Decision Date:	10/15/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/25/2014

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 and Rehabilitation, and is licensed to practice in California. 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:

According to the records made available for review, this is a 54-year-old female with a 2/19/12 date of injury. At the time (6/30/14) of request for authorization for Myofascial trigger release to right upper extremity #6, Myofascial trigger release to cervical spine #6, and Gym membership (months) #3, there is documentation of subjective (pain to right upper extremity 10/10 and 3-4/10 when completed sessions of myofascial trigger release, stopped all medications for 4 weeks when completed myofascial treatments, left upper extremity pain greater than right upper extremity pain, intermittent paresthesias to left 4th-5th digits and always has paresthesias on right 4th and 5th digits) and objective (palpable severe spasms left greater than right trapezius and scalene, cervical range of motion: flexion 45, extension 40, lateral flexion 25 to left and 45 to right, rotation: 60 to right and 40 to left, decreased sensation dermatomal distribution C5-C7 left upper extremity, positive Tinel's right greater than left medial epicondyle, right shoulder range of motion: forward flexion 160, abduction 160, external rotation 90, internal rotation 10, 4/5 strength of rotator cuff, tenderness to palpation acromioclavicular joint) findings, current diagnoses (contusion-hand, wrist sprain/strain, and lateral meniscus tear), and treatment to date (4 sessions of myofascial trigger release (with improved range of motion, decreased pain, and discontinued medications)). Regarding Myofascial trigger release to right upper extremity #6 and Myofascial trigger release to cervical spine #6, there is no documentation that massage therapy is being used as an adjunct to other recommended treatment (exercise). Regarding Gym membership (months) #3, there is no documentation that a home exercise program with periodic assessment and revision has not been effective, there is a need for equipment, and that treatment is monitored and administered by medical professionals.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofascial trigger release to right upper extremity #6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Myofascial trigger release Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MASSAGE THERAPY Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Massage Therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS identifies documentation that massage therapy is being used as an adjunct to other recommended treatment (e.g. exercise), as criteria necessary to support the medical necessity of massage therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of objective functional deficits and functional goals, as criteria necessary to support the medical necessity of massage therapy. In addition, ODG recommends a limited course of physical therapy for patients with a diagnosis of sprained shoulder not to exceed 10 visits over 8 weeks. Within the medical information available for review, there is documentation of diagnoses of contusion-hand, wrist sprain/strain, and lateral meniscus tear. In addition, there is documentation of at least 4 previous myofascial trigger release treatments, objective functional deficits, and functional goals. Furthermore, given documentation that patient stopped all medications for 4 weeks when completed myofascial treatments, there is documentation of functional benefit and improvement as a reduction in the use of medications as a result of myofascial trigger release treatments provided to date. However, despite an associated request for gym membership, there is no (clear) documentation that massage therapy is being used as an adjunct to other recommended treatment (exercise). Therefore, based on guidelines and a review of the evidence, the request for Myofascial trigger release to right upper extremity #6 is not medically necessary.

Myofascial trigger release to cervical spine #6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Myofascial trigger release Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MASSAGE THERAPY Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Massage Therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS identifies documentation that massage therapy is being used as an adjunct to other recommended treatment (e.g. exercise), as criteria necessary to support the medical necessity of massage therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a

reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of objective functional deficits, functional goals and massage used in conjunction with an exercise program, as criteria necessary to support the medical necessity of massage therapy. In addition, ODG recommends a limited course of physical therapy for patients with a diagnosis of regional neck pain not to exceed 9 visits over 8 weeks. Within the medical information available for review, there is documentation of diagnoses of contusion-hand, wrist sprain/strain, and lateral meniscus tear. In addition, there is documentation of at least 4 previous myofascial trigger release treatments, objective functional deficits, and functional goals. Furthermore, given documentation that patient stopped all medications for 4 weeks when completed myofascial treatments, there is documentation of functional benefit and improvement as a reduction in the use of medications as a result of myofascial trigger release treatments provided to date. However, despite an associated request for gym membership, there is no (clear) documentation that massage therapy is being used as an adjunct to other recommended treatment (exercise). Therefore, based on guidelines and a review of the evidence, the request for Myofascial trigger release to cervical spine #6 is not medically necessary.

Gym membership (months) #3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gym membership

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EXERCISE Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Gym Membership

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. ODG identifies documentation that a home exercise program with periodic assessment and revision has not been effective, there is a need for equipment, and that treatment is monitored and administered by medical professionals, as criteria necessary to support the medical necessity of gym membership. Within the medical information available for review, there is documentation of diagnoses of contusion-hand, wrist sprain/strain, and lateral meniscus tear. However, there is no documentation that a home exercise program with periodic assessment and revision has not been effective, there is a need for equipment, and that treatment is monitored and administered by medical professionals. Therefore, based on guidelines and a review of the evidence, the request for Gym membership (months) #3 is not medically necessary.