MAXIMUS Federal Services

Case Number:	CM15-0027291		
Date Assigned:	02/20/2015	Date of Injury:	08/28/2013
Decision Date:	04/03/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/12/2015

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 25 year old female who sustained an industrial related injury on 8/28/13. The injured worker had complaints of upper extremity pain. Physical examination findings included diffuse tenderness over the neck and left upper extremity. Motor and sensation were intact. Treatment included 6 myofascial therapy sessions. Electromyogram and nerve conduction studies obtained on 1/27/15 were noted to be negative. Diagnoses included left wrist sprain rule out triangular cartilage tear and left upper extremity sprain with myofascial pain syndrome. The treating physician requested 6 additional physical therapy sessions to include myofascial therapy to address diffuse tenderness and myofascial pain of the neck and left upper extremity. This was to relieve tension in the muscle and connective tissue and to address the myofascial component of the symptoms. 1 [redacted] exercise kit (medical dynamics) was also requested. On 2/4/15 the requests were non-certified. Regarding additional physical therapy, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted the number of physical therapy visits exceeded the recommended number of visits per guideline recommendations. Regarding the exercise kit, the UR physician cited the MTUS guidelines and noted there was no evidence to support the use of a [redacted] exercise kit as opposed to traditional therapies and home exercise programs. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 additional physical therapy sessions to include myofascial therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Myofascial therapy & Physical therapy (PT) Page(s): 60.

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

Decision rationale: This patient presents with neck and upper extremity pain. The current request is for 6 ADDITIONAL PHYSICAL THERAPY SESSION TO INCLUDE MYOFASCIAL THERAPY. The 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 utilization review states that the patient most recently participated in 4-6 myofascial sessions. The total number of completed therapy visits to date and the objective response to therapy were not documented in the medical reports submitted for this request. The treating physician states that deep tissue massage is designed to relieve severe tension in the muscle and connective tissue to address myofascial component of the symptom. Treatment plan was for the patient to continue with myofascial therapy "to address diffuse tenderness and myofascial pain on her neck and LUE." In this case, the request for 6 additional sessions exceeds what is recommended by MTUS. This request IS NOT medically necessary.

DME: [redacted] Exercise Kit ([redacted]): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309,Chronic Pain Treatment Guidelines exercise Page(s): 46-47.

Decision rationale: This patient presents with neck and upper extremity pain. The current request is for DME: [redacted] EXERCISE KIT. ACOEM, Chapter 12, page 309 states, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise." MTUS Chronic Pain Medical Treatment Guidelines, for exercise, pages 46-47 states: There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The treating physician states that the [redacted] program is "for patients who developed diffuse neck and arm pain secondary to repetitive activities at work." The kit includes stabilization belt, foam wedges, "back on stick," ethafoam rolls, gym ball, air pillow, bulb thermometer, pressure biofeedback, breathing exercise CD, instructional DVD and patient booklet. The ACOEM and MTUS recommends exercises, but states there is no evidence to recommend any particular exercise regimen over any other exercise regimen. In this case, there

are no discussions as to how these items are to be used and what kind of monitoring will be done. This request IS NOT medically necessary.