
Notice of Independent Medical Review Determination

Dated: 10/11/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 5/23/1998
IMR Application Received: 7/16/2013
MAXIMUS Case Number: CM13-0001624

- 1) MAXIMUS Federal Services, Inc. has determined the requested myofascial release x12 sessions **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the requested myofascial release x12 sessions **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

"Primary treating progress report dated 6/06/13 indicated that the claimant presents for follow up evaluation of cervical pain. The severity of condition is 8/10. The claimant is experiencing numbness and tingling in the right and left arm and radicular pain in the right and left arm. The claimant also presents for follow up evaluation of back pain and low back pain. The claimant is experiencing back stiffness and radicular pain in the right and left leg. Back pain is located in the cervical area, lumbar area, upper back, and lowerback. The severity of condition is 7-8/10. The claimant is experiencing stiffness. The claimant is status post clinical massage therapy and continues with one session. The claimant notes improvement in regards to pain, range of motion, and functioning with regards to the cervical spine on the last presentation. Musculoskeletal exam reveals antalgic gait and uses a single point cane. There is 4+/5 strength of the bilateral shoulder abductors, bilateral wrist flexors, bilateral triceps, bilateral wrist extensors, bilateral thumb abductors, and bilateral biceps. There is loss of sensation and strength of the bilateral upper extremities and hands. Neck exam reveals pain to palpation over the C3 to C4, C4 to C5, and C5 to C6 facet capsules, secondary to myofascial pain with triggering and ropey fibrotic banding bilateral, positive Spurling's maneuver, and pain with Valsalva maneuver. There is substantial myofascial pain. Lumbrosacral exam reveals pain with Valsalva maneuver, pain to palpation over L3 to L4 to L5 facet capsules, pain with rotational extension indicative of facet capsular tears, and secondary myofascial with trigger and ropey fibrotic banding bilaterally. The provider recommends myofascial release x 12 sessions since the claimant is not able to undergo surgical intervention."

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (dated 7/16/2013)
- Utilization Review from [REDACTED] (dated 7/3/2013)
- Medical Records from [REDACTED] (dated 9/17/12-6/10/13)
- Medical Records from [REDACTED], Ph.D. (dated 9/25/12-5/21/13)
- Medical Records from [REDACTED] (dated 5/28)
- Medical Records from [REDACTED] (dated 6/3/13)
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments pg.50

1) Regarding the request for myofascial release x12 sessions:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009), pg. 50, which is part of the Medical Treatment Utilization Schedule. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on May 23, 1998 to the neck. The medical report of 6/23/13 documents the employee was status post clinical massage with one session remaining. The employee reported some benefit from the massage therapy. The medical report of 6/23/13 notes some benefit from previous massage in pain levels, range of motion, and functioning with the regard to the cervical spine. The request is for 12 sessions of myofascial release.

The MTUS Chronic Pain Medical Treatment guidelines indicate massage therapy lacks long-term benefit and does not address the underlying causes of pain. However, it is recommended as an option and should be utilized as an adjunct to other recommended treatment such as supervised active therapeutic interventions with documented functional improvement in pain. While the medical records provided for review do note reported improvement from the previous massage therapy, there is no documentation of objective functional improvements which would meet guideline criteria for continuing. The request for 12 sessions of myofascial release **is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.