

Case Number:	CM13-0031419		
Date Assigned:	12/04/2013	Date of Injury:	12/27/2008
Decision Date:	01/16/2014	UR Denial Date:	09/28/2013
Priority:	Standard	Application Received:	10/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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, Texas, and Wisconsin. 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 physician 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:

53 yo male with date of injury (DOI) 12/27/2008 with lower back pain, knee pain and right shoulder pain. Patient was approved for shoulder arthroscopy but patient changed his mind and declined the surgery. Patient was taking Norco BID, Zofran, and Levaquin. From the medical record, it appeared that the patient might have received some physical therapy before surgery. There wasn't any clear documentation whether physical therapy had helped. On 9/9/13, request was submitted for functional capacity evaluation (FCE) in order to assist in permanent and stationary (P&S) evaluation. Patient was also experiencing anxiety as the result of pain and loss of function.

IMR ISSUES, DECISIONS AND RATIONALES

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

Completed physical therapy x 15 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine Page(s): 99.

Decision rationale: According to MTUS guidelines, physical medicine allow for fading of treatment frequency. Passive therapy (those treatment modalities that do not require energy

expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices (Colorado, 2002; Airaksinen, 2006). Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in Complex regional pain syndrome (CRPS) (Li, 2005). The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment (Fritz, 2007). In this case, this patient did not undergo right shoulder surgery. The patient had some PT without any clear documentation of its effectiveness or functional improvement. The patient was being considered for P&S status as of 9/9/13. Given the chronicity of the shoulder injury, patient should have been progressed to home therapy. Therefore, the request for 15 visits of PT is not supported by the guidelines.

Psychology visits: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Intervention Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

Decision rationale: According to MTUS guidelines, behavioral interventions is recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. The ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain indicate that screening for patients with risk factors for delayed recovery, including fear avoidance beliefs, which can be done via the Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone. The initial trial of 3-4 psychotherapy visits over 2 weeks with evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). In this case, the patient developed anxiety over pain and

loss of function. As the patient was being considered for permanent and stationary (P&S) status, a psychological evaluation would be helpful in determine if other factors might have contributed to the underlying symptoms and to guide treatment. Therefore a psychological evaluation is within the guidelines recommendation.