

Case Number:	CM14-0036981		
Date Assigned:	06/25/2014	Date of Injury:	01/15/2010
Decision Date:	07/23/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	03/27/2014

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:

This 52-year-old patient sustained an injury on 1/15/10 to his neck, shoulders and upper extremities, during the course of his normal work duties, while employed by [REDACTED]. The request(s) under consideration include physical therapy two (2) times a week for six (6) weeks to treat the cervical spine and a multidisciplinary pain program for functional restoration and a screening test for functional restoration program. The conservative care has included at least fourteen (14) physical therapy (PT) sessions, six (6) acupuncture visits, medications, and modified activities. The patient also had cervical spine fusion surgery on 1/15/11 with thirty (30) PT visits during November 2010 to July 2011. A report of 2/28/14 from the provider, noted ongoing chronic pain symptoms. An exam showed tenderness, restricted range of motions, stiffness in the cervical spine with limited range of motion without specified degrees or planes. There was no mention of any positive orthopedic provocative testing or noted change of neurological deficits identified. The request(s) for physical therapy two (2) times a week for six (6) weeks to treat the cervical spine and multidisciplinary pain program for functional restoration and a screening test for functional restoration program were non-certified on 3/18/14, citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS TO TREAT THE CERVICAL SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: It is now over 3-1/2 years since the last surgery of January 2011, with continued chronic pain symptoms and unchanged clinical findings. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist, due to the complexity and sophistication of the therapy and the physical condition of the patient. There is no clear measurable evidence of progress with the previous physical therapy (PT) sessions, including milestones of increased range of motion (ROM), strength, and functional capacity. The Chronic Pain Guidelines allow for nine to ten (9-10) visits of physical therapy with fading of treatment to an independent self-directed home program. The provider's dated report has no documentation of new acute injury or flare-up to support for formal physical therapy as the patient should continue the previously instructed independent home exercise program for this chronic injury of 2010. Multiple medical reports have unchanged chronic pain symptoms, unchanged clinical findings with continued treatment plan for physical therapy without demonstrated functional benefit. Without documentation of the current deficient baseline, with clearly defined goals to be reached, the medical indication and necessity for formal physical therapy has not been established. The request is not medically necessary and appropriate.

MULTIDISCIPLINARY PAIN PROGRAM FOR FUNCTIONAL RESTORATION, A SCREENING TEST FOR FUNCTIONAL RESTORATION PROGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-34.

Decision rationale: It is now over 3-1/2 years since last surgery of January 2011, with continued chronic pain symptoms and unchanged clinical findings. The Chronic Pain Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/psychological treatment, physical or occupational therapy, and at least one (1) other rehabilitation oriented discipline, not seen here. The criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; a level of disability or dysfunction; no drug dependence or problematic or significant opioid usage; and a clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above, as the patient has unchanged chronic pain symptoms and clinical presentation, without any aspiration to return to work for this chronic injury with delayed recovery beyond the recommended time frame for a successful outcome. The patient has remained not working, on chronic opioid medication, without functional improvement from extensive treatments already rendered. There is also no psychological issues demonstrated or evaluation documenting

medical necessity for a functional restoration program. The request is not medically necessary and appropriate.