

<b>Case Number:</b>	CM14-0061455		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	04/26/2011
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	04/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

The patient is a 50-year-old female who has submitted a claim for Cervical Spine Herniated Nucleus Pulposus, Post-operative Right Carpal Tunnel Syndrome, Shoulder Impingement, and Lumbar Spine Herniated Nucleus Pulposus associated with an industrial injury date of April 26, 2011. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of bilateral upper extremity and hand pain, left greater than right, associated with numbness, tingling, and burning to the fingers. She also complained of dull, aching right shoulder pain radiating to the back. She also had neck pain that is dull and achy that becomes sharp and stabbing. She also complained of lumbar spine pain associated with numbness of the feet, which was worse with prolonged standing. On physical examination, there was difficulty in head turning and arm gesturing. Cervical spine range of motion was decreased on all planes. There was paravertebral and anterior scalene muscle spasm bilaterally. Cervical distraction, maximal foraminal compression, and shoulder depression tests were positive bilaterally. There was also tenderness and weakness of the right shoulder. Apley scratch, supraspinatus, and impingement tests were positive on the right. There was tenderness of the right hand. Phalen's, Tinel's, and carpal tunnel tests were positive bilaterally. There was paravertebral thoracolumbar muscle spasm. Lumbar spine range of motion was limited. Straight leg raise tests were positive bilaterally. Bragard's, Patrick-Faber, iliac compression, and Kemp's tests were positive bilaterally as well. No sensory deficits of the lower extremities were noted. Deep tendon reflexes were symmetrical and normal. Treatment to date has included medications, an unknown number of physical therapy sessions for the hand and shoulder, home exercise program, lumbar spine epidural steroid injections, trigger point injections, left carpal tunnel release, and left shoulder arthroscopic surgery. Utilization review from April 24, 2014 denied the request for Functional Restoration Program because guideline criteria were not met; Physical Therapy 6 visits because

there were no specific functional deficits outlined or treatment goals provided; and Follow-up Office Visit with Orthopedist because there were no objective examination findings suggestive of red flag conditions requiring an orthopedic referral.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Functional Restoration Program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs; Chronic Pain Programs Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-32.

**Decision rationale:** According to pages 30-32 of the CA MTUS Chronic Pain Medical Treatment Guidelines, functional restoration program participation may be considered medically necessary when all of the following criteria are met: (1) an adequate and thorough evaluation including baseline functional testing was made; (2) previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) there is significant loss of ability to function independently; (4) the patient is not a candidate where surgery or other treatments would clearly be warranted; (5) the patient exhibits motivation to change; and (6) negative predictors of success have been addressed. In this case, there was no adequate baseline examination. In addition, there was no discussion regarding failure of previous treatment or absence of other options likely to result in improvement. Negative predictors of success were also not addressed. The criteria were not met. Therefore, the request for Functional Restoration Program is not medically necessary.

**Physical Therapy 6 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines - Work Loss Data Institute, 7th Edition, Treatment Index; Low Back (updated 02/20/2012) Physical Therapy; Official Disability Guidelines, Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Physical Medicine Page(s): 98-99.

**Decision rationale:** According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, physical therapy was requested in order to re-educate the patient on exercises and ensure that she was performing them correctly in order to prevent the patient from regressing any

further. Records showed that the patient previously underwent an unknown number of physical therapy sessions for the hand and shoulder but objective evidence of functional improvement was not documented. Moreover, the present request failed to identify the specific body part to be subjected to physical therapy. The request is incomplete. Therefore, the request for Physical Therapy 6 visits is not medically necessary.

**Follow-up Office Visit with Orthopedist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 49. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition: chapter 7; Independent Consultations , pg 127; Work Loss Data Institute, Official Disability Guidelines, Treatment in Workers Compensation, 5th Edition, 2007 or current year - Chapter on the Hip. Office visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits.

**Decision rationale:** CA MTUS does not specifically address office visits. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, follow-up with an orthopedic surgeon was requested due to the patient's ongoing neck and low back pain. However, the patient's neck and low back pain were already being managed by his primary physician. There was no discussion regarding contemplated procedures or treatment options that require the expertise of an orthopedic surgeon. Therefore, the request for Follow-up Office Visit with Orthopedist is not medically necessary.