

Case Number:	CM15-0131901		
Date Assigned:	07/20/2015	Date of Injury:	08/20/2012
Decision Date:	08/14/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/08/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 (IW) is a 52 year old male who sustained an industrial injury on 08/20/2012. The airbags in the work vehicle he was driving deployed while going about 44 miles per hour causing him to strike his head on the airbag and steering column. He had a loss of consciousness for an unknown length of time. He was seen for a closed head injury and post concussive symptoms. He has had major depression and headaches, and was diagnosed as having cervical radiculitis, cervical sprain/strain, lumbar radiculitis, sprain lumbar region, post-traumatic stress disorder, depressive disorder not elsewhere classified, cognitive disorder, and encounter for long-term use of other medications. Treatment to date has included lumbar epidural steroid injections, psychological treatment, hearing aids, sacroiliac (SI) joint injections, and a left SI joint Neurotomy, medications, and medication management. Currently, the injured worker complains of neck pain radiating to the left temple and left periorbital areas with a headache. This is worse with noise, bright light, and sounds. He has no prodromal no nausea, no vomiting. Neck pain and headaches appear to be related, and the worker has had occipital nerve blocks in the past which helped decrease pain 70-100%. His medications include Abilify, Adderall, Ambien, Cymbalta, Gabapentin, Hydrocortisone, Ketoprofen, Minipress, Tramadol, and Valium. In his physical examination, the active range of motion of the cervical spine is globally decreased in all directions due to pain and guarding. Active range of motion of the lumbar spine is decreased about 25% due to pain and guarding. Motor strength is 5 on a scale of five and equal in the lower extremities. Deep tendon reflexes are 1+ and equal in the upper extremities and 3+ and equal in the lower extremities. He has localized tenderness to palpation in the area of occipital nerve. The plan of care includes requesting a left occipital nerve block for his headaches, requesting physical therapy to address a comprehensive home program for his neck and low back for

ongoing self-management. Three to five sessions of physical therapy were requested to cover the few additional sessions for instruction due to his cognitive issues. Pain management counseling will also be requested. A request for authorization was made for the following: 1. Left Occipital Nerve Block. 2. Physical Therapy x 5. 3. Pain Management Counseling x 12.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x5: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to MTUS guidelines, Physical Medicine is recommended as indicated below. 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 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) There is no documentation of objective findings that support musculoskeletal dysfunction requiring more physical therapy sessions. There is no documentation of the outcome of previous physical therapy sessions and home exercise. There is no documentation supporting additional physical therapy sessions. Therefore, Physical Therapy x5 is not medically necessary.

Pain Management Counseling x 12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. There is no clear documentation that the patient needs a 12 visit for medications management and counseling per MTUS criteria. There is no clear documentation that the patient had delayed recovery or a medical condition that require a frequent adjustment of the patient medications. The provider did not document the reasons, the specific goals and end point for follow up visits. Therefore, the request for Pain Management Counseling x 12 is not medically necessary.