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| Case Number: | CM15-0134836 | | |
| Date Assigned: | 07/23/2015 | Date of Injury: | 03/04/2013 |
| Decision Date: | 08/19/2015 | UR Denial Date: | 06/19/2015 |
| Priority: | Standard | Application Received: | 07/13/2015 |

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: North Carolina

Certification(s)/Specialty: Family Practice

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 is a 55 year old female who sustained a work related injury March 4, 2013. According to an orthopedic progress report, dated April 22, 2015, the injured worker presented for follow-up evaluation. She continues to have diffused aching discomfort in her neck and back with difficulty sleeping. Physical examination reveals some impingement in both shoulders. Active forward flexion is 140 degrees, abduction is 100 degrees, and external rotation is 50 degrees. Increased tone is present throughout the paraspinal musculature; however no gross focal point tenderness or spasm. Assessments are cervicgia with MRI of the cervical spine, dated June 2013 showing evidence of diffuse degenerative cervical disk disease and bilateral foraminal narrowing C4-C5 as well as right foraminal narrowing C3-C4 without gross compression; bilateral stage III impingement, left more symptomatic than right, with evidence of supraspinatus tendinopathy; bilateral lateral epicondylitis with normal ultrasounds of the elbows; anxiety and depression; diffuse myofascial pain with ill-defined etiology. At issue, is the request for authorization for a functional restoration program for the cervical spine and evaluation, physical therapy and occupational therapy for the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program (FRPs) Page(s): 30-34.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration program Page(s): 49.

Decision rationale: The California chronic pain medical treatment guidelines section on functional restoration programs states: Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see chronic pain programs), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see chronic pain programs. While functional restoration programs are recommended per the California MTUS, the length of time is for 2 weeks unless there is documentation of demonstrated efficacy by subjective and objective gains. The request does not define an amount of time and therefore the request is not medically necessary as it does not meet guideline recommendations.

Evaluation (Physical Therapy, Occupational Therapy) for the Cervical Spine: 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): 98-99.

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: 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) Physical Medicine 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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is not defined and therefore does not meet guideline recommendations as outlined above and thus the request is not medically necessary.