

Case Number:	CM15-0139272		
Date Assigned:	07/29/2015	Date of Injury:	03/19/2011
Decision Date:	08/26/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/17/2015

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: Texas, Florida, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 67 year old female, who sustained an industrial injury on 3/19/2011. The details regarding the initial injury were not documented in the medical records submitted for this review. Diagnoses include herniated nucleus pulposus with spinal cord compression and progressive neurologic deficit, bilateral upper extremity radiculopathy, status post lumbar microdiscectomy, status post cervical fusion 12/3/14. Treatments to date include medication therapy and physical therapy. Currently, she complained of neck and low back pain as well as constant headaches. There was radiation to bilateral upper extremities with numbness and tingling. On 6/8/15, the physical examination documented cervical tenderness and decreased range of motion. The plan of care included additional cervical physical therapy and a pain management evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued post op physical therapy, cervical spine, two times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
 Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 of 127.

Decision rationale: This claimant was injured over four years ago with a herniated nucleus pulposus with spinal cord compression and progressive neurologic deficit, bilateral upper extremity radiculopathy, status post lumbar microdiscectomy, and status post cervical fusion in December 2014. Treatments have been medication and physical therapy. There is still neck and low back pain as well as constant headaches. As of June 2015, there was cervical tenderness and decreased range of motion. The request is for more therapy. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are 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; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy was not medically necessary.

Pain management evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2004, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: As shared previously, this claimant was injured over four years ago with a herniated nucleus pulposus with spinal cord compression and progressive neurologic deficit, bilateral upper extremity radiculopathy, status post lumbar microdiscectomy, and status post cervical fusion in December 2014. Treatments have been medication and physical therapy. There is still neck and low back pain as well as constant headaches. As of June 2015, there was cervical tenderness and decreased range of motion. The request is for a specialist pain management evaluation. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit

from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.