MAXIMUS Federal Services

Case Number:	CM15-0141997		
Date Assigned:	07/31/2015	Date of Injury:	12/01/2014
Decision Date:	08/31/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/21/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal 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 60-year-old female who sustained an industrial injury on 12/01/2014 when she was assaulted with loss of consciousness. The injured worker was diagnosed with headaches, cervical musculoligamentous sprain, myofascitis, anxiety disorder and post-traumatic stress disorder. Treatment to date has included diagnostic testing, physical therapy, chiropractic therapy, psychiatric evaluation, treatment, and medications. According to the primary treating physician's progress report on June 15, 2015, the injured worker continues to experience achy headaches rated at 7 out of 10 on the pain scale and neck pain and stiffness rated as 8 out of 10. Examination demonstrated 3 plus tenderness to palpation of the cervical paravertebral muscles with spasm. Cervical range of motion was decreased and painful. Cervical compression and shoulder depression caused pain. Upper extremity dermatomes were intact bilaterally and motor strength in the upper extremities was documented at 5 plus out of 5. Deep tendon reflexes and coordination were intact. Cranial nerves tested were within normal limits. Current medication is noted as Viibryd. Treatment plan consists of psychotherapy and cognitive behavioral therapy (CBT) and the current request for physical therapy (18 sessions), Functional Capacity Evaluation (FCE) referral and neurologist referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Physical Therapy visits to include kinetic activities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 18 physical therapy visits to include kinetic activity are not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are emotional headache; cervical musculoligamentous injury; cervical myofasciitis; cervical disc protrusion with bilateral compromise; left hand contusion; and psychology component. The date of injury is December 1, 2014. The request for authorization is June 22, 2015. According to a June 15, 2015 progress note by the chiropractic provider, the injured worker had subjective complaints of headache 7/10 and neck pain 8/10. There were psychology complaints. Objectively, there was decreased range of motion at the cervical spine with tenderness to palpation and spasm. The treating provider requested 18 physical therapy sessions. The guidelines recommend a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). There is no six visit clinical trial documented in the medical record. The treating provider exceeded the recommended guidelines when ordering 18 physical therapy sessions. Consequently, absent clinical documentation with a six visit clinical trial and objective functional improvement associated with the six visit clinical trial, 18 physical therapy visits to include kinetic activity are not medically necessary.

Referral for FCE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Pages 137-138.

Decision rationale: Pursuant to the ACOEM, referral for functional capacity evaluation is not medically necessary. The guidelines state the examiner is responsible for determining whether the impairment results from functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether work restrictions are based on limited capacity, risk of harm or subjective examinees tolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the workplace. For these reasons, it is problematic to rely solely upon functional capacity evaluation results for determination of

current work capabilities and restrictions. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. Guideline criteria functional capacity evaluations include prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modify job, the patient is close to maximum medical improvement, and clarification any additional secondary conditions. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. In this case, the injured worker's working diagnoses are emotional headache; cervical musculoligamentous injury; cervical myofasciitis; cervical disc protrusion with bilateral compromise; left hand contusion; and psychology component. The date of injury is December 1, 2014. The request for authorization is June 22, 2015. According to a June 15, 2015 progress note by the chiropractic provider, the injured worker had subjective complaints of headache 7/10 and neck pain 8/10. There were psychology complaints. Objectively, there was decreased range of motion at the cervical spine with tenderness to palpation and spasm. There were no neurologic deficits documented in the record. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. There is no documentation indicating the injured worker is planning on a return to work. There is no clinical rationale in the medical record for the functional capacity evaluation. There is no prior unsuccessful return to work attempts. There is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the workplace. For these reasons, it is problematic to rely solely upon functional capacity evaluation results for determination of current work capabilities and restrictions. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and a clinical rationale for the functional capacity evaluation, referral for functional capacity evaluation is not medically necessary.

Referral to a neurologist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Page 127.

Decision rationale: Pursuant to the ACOEM, referral to neurologist is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates; for certain, antibiotics require close monitoring. In this case, the injured worker's working diagnoses are emotional headache; cervical musculoligamentous injury; cervical myofasciitis; cervical disc protrusion with bilateral compromise; left hand contusion; and psychology component. The date of injury is December 1, 2014. The request for authorization is June 22, 2015. According to a

June 15, 2015 progress note by the chiropractic provider, the injured worker had subjective complaints of headache 7/10 and neck pain 8/10. There were psychology complaints. Objectively, there was decreased range of motion at the cervical spine with tenderness to palpation and spasm. There were no neurologic deficits documented in the record. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. Subjective complaints include headache and neck pain. Objectively, there are no neurologic deficits documented. There is no clinical indication or rationale for a neurology consultation in the medical record. Consequently, absent clinical documentation with a clinical indication and rationale and objective clinical findings with a neurologic deficit, referral to neurologist is not medically necessary.