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| Case Number: | CM15-0216622 | | |
| Date Assigned: | 11/06/2015 | Date of Injury: | 07/12/2007 |
| Decision Date: | 12/21/2015 | UR Denial Date: | 10/12/2015 |
| Priority: | Standard | Application Received: | 11/03/2015 |

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 64 year old, female who sustained a work related injury on 7-12-07. A review of the medical records shows she is being treated for neck and back pain. In the progress notes dated 8-24-15 and 9-25-15, the injured worker reports worsening symptoms with shooting pain down her right arm to the C6 nerve root distribution. She is starting with some "drawing of the left hand." She states significant loss of use of both arms. She is unable to cross her legs secondary to her spine. In a Neurosurgical-Neurological Reevaluation Report dated 8-26-15 by another physician, "she is unable to take a bath. She has difficulty brushing her teeth, dressing, combing her hair and going to the toilet. She is unable to type. She has difficulty writing. She has difficulty with standing, sitting, reclining, walking normally and climbing stairs. She has difficulty with feeling contact on her skin and seeing. She has difficulty with grasping and lifting. She has difficulty sleeping restfully and normally at night time." Upon physical exam dated 9-25-15, she has tenderness and spasm of paracervical muscles. She has some decreased range of motion in neck. She has tenderness and spasm in the paralumbar muscles. She has decreased lumbar range of motion. She has a positive straight leg raise with left leg. She has diminished sensation over the L5-S1 nerve root distribution in left leg. Treatments have included cervical spine surgery, medications, home exercises, and H wave therapy-some helpful. Current medications include Tramadol, Diclofenac and Omeprazole (from other notes). She is temporarily totally disabled. The treatment plan includes requests for chronic pain management, for a functional restoration program and for a course of physical therapy. The Request for Authorization dated 10-5-15 has requests for physical therapy, x-rays and a referral for a

functional restoration program. In the Utilization Review dated 10-12-15, the requested treatment of physical therapy for back x 18 was modified to physical therapy for back x 10. The requested treatment of a functional restoration program is not medically necessary.

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 Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

Decision rationale: Submitted reports have not presented any psychological evaluation clearance or issues with unchanged clinical findings for this chronic injury. The patient has not shown any motivation for any change in work status and reports have no mention of specific benefit with adequate response from previous therapy treatment rendered with further demonstrated need for this chronic 2007 injury with long-term ongoing treatment. Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and A clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged symptoms and clinical presentation, without any aspiration to improve work status without tapering of opiate use. Additionally, there is treatment plan for 18 PT sessions along with x-rays, a contraindication per guidelines criteria as all treatment options have not been exhausted to support for the FRP for this chronic injury, passed 8 years with negative predictors for successful outcome. The Functional restoration program is not medically necessary and appropriate.

Physical therapy, back qty: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the request for PT was modified to 10 sessions. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased

ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2007 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy, back qty: 18.00 is not medically necessary and appropriate.