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| Case Number: | CM15-0058451 | | |
| Date Assigned: | 04/03/2015 | Date of Injury: | 04/30/2013 |
| Decision Date: | 05/04/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 03/27/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 33 year old female who sustained an industrial injury on 04/30/13. Initial complaints and diagnoses are not available. Treatments to date include physical therapy, acupuncture, and medications. Diagnostic studies include nerve conduction studies, and a MRI of the cervical spine. Current complaints include neck pain. In an AME evaluation dated 02/05/15 the evaluator reports the plan of care as surgery and cervical epidural steroid injections. The requested treatments are physical therapy and a pain management referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (no duration and frequency): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical

Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Physical Therapy, ODG Preface ½ Physical Therapy.

Decision rationale: MTUS refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG writes regarding neck and upper back physical therapy, "Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion." ODG further quantifies its cervical recommendations with Cervicalgia (neck pain); Cervical spondylosis = 9 visits over 8 weeks Sprains and strains of neck = 10 visits over 8 weeks Regarding physical therapy. ODG states "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 a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Medical records indicate that the patient already received physical therapy and acupuncture. The treating physician does not detail extenuating circumstances that would warrant exception to the guidelines or state why a home exercise program would not suffice. In addition, the physician did not state the length of time or program detail for the requested therapy. As such, the request for Physical therapy (no duration and frequency) is not medically necessary.

Pain management referral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM body parts chapters 8-14 page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs.

Decision rationale: MTUS states, "Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed." ODG states concerning chronic pain programs "(e) Development of psychosocial

sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function." The treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six MTUS criteria for a chronic pain management program. As such the request for a Pain Management Referral is not medically necessary at this time.