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| Case Number: | CM15-0116706 | | |
| Date Assigned: | 06/24/2015 | Date of Injury: | 11/15/1996 |
| Decision Date: | 07/23/2015 | UR Denial Date: | 05/26/2015 |
| Priority: | Standard | Application Received: | 06/16/2015 |

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 53-year-old male, who sustained an industrial/work injury on 11/15/96. He reported initial complaints of neck pain. The injured worker was diagnosed as having cervical spine disc bulges, lumbar spine surgeries x 4, and right shoulder strain. Treatment to date has included medication, diagnostics, and epidural steroid injection in 1/2015. Currently, the injured worker complains of chronic neck, low back, and right shoulder pain. Per the primary physician's progress report (PR-2) on 5/6/15, examination revealed more perspiration with use of Zanaflex. Pain was reduced by 85% from epidural injection in January. There was light touch sensation to the left lateral shoulder, left thumb tip, left long tip, and left small tip. Current plan of care included pain consult, spine surgeon consult, and additional therapy for cervical and lumbar spine and right shoulder. The requested treatments include 24 physical therapy sessions, cervical spine, lumbar spine, (R) shoulder, pain medicine follow up visit, and spine surgeon follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

24 physical therapy sessions, cervical spine, lumbar spine, r. shoulder: 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): 76-79.

Decision rationale: According to MTUS guidelines, Physical Medicine is 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) There is no documentation of the efficacy and outcome of previous physical therapy sessions. The patient underwent 10 sessions of physical therapy without clear documentation of efficacy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 24 physical therapy sessions, cervical spine, lumbar spine, r. shoulder is not medically necessary.

Pain medicine follow up visit: 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 Assessing Red Flags and Indication for Immediate Referral, Chronic pain programs, early intervention Page(s): 171, 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a surgery evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early

intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks.” (Mayer 2003). The provider did not document lack of pain and functional improvement that require a follow up with a pain medicine physician. The requesting physician did not provide a documentation supporting the medical necessity for a follow up evaluation. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist for the patient pain. Therefore, the request for Follow up with a pain medicine physician is not medically necessary.

Spine surgeon follow up: 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 Assessing Red Flags and Indication for Immediate Referral, Chronic pain programs, early intervention Page(s): 171, 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a surgery evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (e) The patient is not a candidate where surgery or other treatments would clearly be warranted. (f) Inadequate employer support. (g) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks.” (Mayer 2003). There is no documentation of acute changes in the patient's neurologic or orthopedic exam that require for a spine surgeon follow-up. The requesting physician did not provide a documentation supporting the medical necessity for a follow up evaluation. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist for the patient pain. Therefore, the request for Spine surgeon follow up is not medically necessary.