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| Case Number: | CM15-0126553 | | |
| Date Assigned: | 07/13/2015 | Date of Injury: | 02/12/2014 |
| Decision Date: | 08/06/2015 | UR Denial Date: | 06/19/2015 |
| Priority: | Standard | Application Received: | 06/30/2015 |

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 50 year old male, who sustained an industrial injury on 2/12/2014. The injured worker was diagnosed as having right wrist triangular fibrocartilage complex tear, ligament tears, ulnar positive variance, status post open reduction and internal fixation with contracture right shoulder, left shoulder compensatory strain, right tennis elbow, cervical multi-level disc herniation and degenerative disc disease, right upper extremity radiculitis, low back pain with degenerative disc disease with osteophytes, right knee medial and lateral meniscus tears, left knee strain, right heel pain, headaches, stress, and anxiety. Treatment to date has included diagnostics, right shoulder surgery in 2014, physical and aquatic therapy, massage, acupuncture, and medications. Currently, the injured worker complains of right shoulder pain, doing better, but denied surgery for his left wrist. He reported denial of the further indicated aquatic therapy that was giving him the benefit of functional improvement, pain relief, and improved range of motion. He now stated that his range of motion was limited and he had increasing right wrist pain. The treatment plan included a C7-T1 intralaminar epidural steroid injection, referral for cognitive behavioral therapy and mindfulness therapy (2-3x6), and physical therapy and aqua therapy for the left shoulder and left knee (2-3x6). His work status was total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy and Aqua Physical Therapy, Left Shoulder, Left Knee, 2-3 times wkly for 6 wks, 12-18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy; Physical Medicine Page(s): 22; 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Aquatic Therapy does not seem appropriate, as the patient has received land-based Physical therapy. There is no records indicating intolerance of treatment, incapable of making same gains with land-based program nor is there any medical diagnosis or indication to require Aqua therapy at this time. The patient is not status-post recent lumbar or knee surgery nor is there diagnosis of morbid obesity requiring gentle aquatic rehabilitation with passive modalities and should have the knowledge to continue with functional improvement with a Home exercise program. The patient has completed formal sessions of PT and there is nothing submitted to indicate functional improvement from treatment already rendered. There is no report of new acute injuries that would require a change in the functional restoration program. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this injury. Per Guidelines, 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. Submitted reports have not adequately demonstrated the indication to support for the pool therapy. The Physical Therapy and Aqua Physical Therapy, Left Shoulder, Left Knee, 2-3 times wkly for 6 wks, 12-18 sessions is not medically necessary and appropriate.

Cervical Intralaminar Epidural Steroid Injection C7-T1 (thoracic): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not

provided here. Submitted reports have not demonstrated any specific neurological deficits or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, progressive neurological deficit, or red-flag conditions to support for pain procedure. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or identified pathological lesion noted. Criteria for the epidurals have not been met or established. The Cervical Intralaminar Epidural Steroid Injection C7-T1 (thoracic) is not medically necessary and appropriate.

Psychology referral: Cognitive behavioral therapy with mindfulness therapy, 2-3 times wkly for 6 wks, 12-18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive behavioral therapy Page(s): 23. Decision based on Non-MTUS Citation ACOEM Chapter 7: Independent Medical Examinations and Consultations, page 127; Official Disability Guidelines: Cognitive behavioral therapy (CBT) guidelines for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, page 23.

Decision rationale: Submitted reports have not described what psychological complaints, clinical findings, or diagnoses to support for unspecified cognitive behavioral therapy for diagnoses involving cervical and lumbar disorders. There are no supporting documents noting what psychotherapy are needed or identified what specific goals are to be attained from the psychological treatment beyond the current medical treatment received to meet guidelines criteria. MTUS guidelines support treatment with functional improvement; however, this has not been demonstrated here whereby independent coping skills are developed to better manage episodic chronic issues, resulting in decrease dependency and healthcare utilization. Current reports have no symptom complaints, clinical findings or diagnostic procedures to support for the CBT treatment (unspecified). Additionally, if specific flare-up has been demonstrated, the guidelines allow for initial trial of 3-4 sessions with up to 6-10 visits over 5-6 weeks; however, does not recommend 18 sessions of CBT treatment without identified functional benefit. The Psychology referral: Cognitive behavioral therapy with mindfulness therapy, 2-3 times wkly for 6 wks, 12-18 sessions is not medically necessary and appropriate.