Case Number:	CM13-0071142		
Date Assigned:	01/08/2014	**Date of Injury:**	02/05/2009
Decision Date:	04/23/2014	**UR Denial Date:**	12/04/2013
Priority:	Standard	**Application Received:**	12/26/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 53 year old male who was injured on 02/05/2009 while he fell at work resulting in a cervical spine injury. Prior treatment history has included physical therapy and electroacupuncture. Medications include: oxycodone, Ambien and Lyrica. The patient underwent 3 cervical spine surgeries with the most recent being an ACDF at C3-4 and C7-T1. He also received revision ACDF at C4-5, C5-6, and C6-7 on 01/28/2013. Diagnostic studies reviewed include: CT Cervical Spine +3D dated 11/05/2012 1. Interbody fusion changes at C4-7 with plate and screw placement at C4-5. No definite bony fusion at C5-6. 2. Central disc protrusion at C3-4 with severe dural compression better seen on the MRI dated 11/06/2012. 3. Moderate neural foraminal stenosis of the right at C3-4 and C5-6 and on the left at C4-5 and C5-6. Mild neural foraminal stenosis on the left at C3-4 and on the right at C4-5 and bilaterally at C6-7 and C7-T1. MRI of the Cervical Spine w/wo Contrast 1. Interbody fusion at C3-C7 with transfer lesion disc protrusion at C3-4 causing severe dural compression and flattening of the cord with abnormal cord signal. Mild right and mild left neural foraminal stenosis at this level as well. 2. Mild to moderate dural compression contacting the cord posteriorly at C7-T1. Moderate bilateral neural foraminal stenosis at this level. 3. Mild dural compression at C4-5, C5-6, C6-7 and T1-2 levels. Moderate neural foraminal stenosis on the right at C5-6 and on the left at C4-5 and C5-6. Mild neural foraminal stenosis on the right at C4-5 and C6-7 and on the left at C6-7. Chest X-ray PA & Lateral: Reveals no acute cardiopulmonary disease. Pathology Report dated 01/29/2013 description: Received in no fixative are one metallic plate, two metallic screws, one of which is broken, and a partial metallic cage. Right Shoulder X-ray dated 01/31/2013: No acute fracture or dislocation. Moderate degenerative change of the acromioclavicular joint. X-ray of the Cervical Spine: Extensive postoperative changes, status post anterior and posterior bilateral cervical fusion. No fracture. X-ray of the Cervical Spine, 2-3 Views dated 09/23/2013: Status post

cervical and upper thoracic fusion. Oasis Acupuncture note dated 10/03/2013 documented the patient has neck, right shoulder and back pain since date of injury. Neck pain level a 9/10. Low back pain at 7/10. Level of pain of right shoulder at 8/10. There is constant bilateral numbness to all fingers dominant in 4th and 5th. Radiating bilateral leg pain 3 x weekly with movement. Slight numbness at bottom of feet. The pain is worse all movement, turning, twisting, bending forward and backward and sleep is disturbed. He has frontal headaches and occipital. Pain benefits from heat, prescribed pain meds. Objective findings on exam include palpation: tenderness and tension palpable at the cervical and lumbar muscles. Observation: Atrophy bilaterally between 1st and 2nd fingers. Diagnoses: 1. Cervical sprain 2. Shoulder sprain, unspecified 3. Lumbosacral joint sprain Neurosurgical report dated 10/18/2013 documents the patient is progressing well with physical therapy and is showing increased cervical spine flexibility and stability allowing for increased function. The patient reports strength is increasing with T.E. and a home exercise program. However, it is noted that the patient continues to be limited by bilateral upper extremity weakness and pain due to radiating symptoms from the neck with pain and numbness in the upper extremities. Recommendations include continued physical therapy to increase range of motion, strength, endurance and stability. Plan: Requesting authorization for continued physical therapy at two times a week for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the cervical spine, twice (2) a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99,Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: According to the CA MTUS guidelines, postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks, postsurgical treatment period is 6 months. In the chronic phase of care, Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus activeself-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. The medical records do not document the total number of postoperative physical therapy sessions the patient has completed to date. According to the 10/18/2013 medical report, the patient demonstrated increased cervical spine flexibility and stability allowing for increased function, and reported strength increasing with therapy and a home exercise program. It is not clearly evident that the patient presents with significant residual functional loss that would necessitate additional supervised therapy. It is reasonable that at this juncture, the patient should be well-versed in an independently of clinical exercise program, which to utilize on a routine basis to maintain improvement levels. Independence and the importance of an on-going exercise regime should be emphasized. The medical necessity of the requested physical therapy has not been established at this time.