

Case Number:	CM14-0122570		
Date Assigned:	08/06/2014	Date of Injury:	12/16/2012
Decision Date:	09/18/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/04/2014

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 Physical Medicine & Rehabilitation 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:

This patient sustained an injury to her neck, bilateral upper extremities (elbows, wrists, hands) from repetitive work on 12/16/12 while employed by [REDACTED], Risk Management, Workers' Compensation. Request(s) under consideration include MRI Cervical Spine, Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY, and Physical Therapy two to three times a week for six weeks, Bilateral Shoulder and Left Elbow 18 QTY. Diagnoses include cervical disc degeneration. Conservative care has included medications, physical therapy, cervical epidural steroid injections (9/26/13) without substantial relief, and modified activities/rest. Per reports from the provider, the patient has chronic continued neck, bilateral shoulders/arm pain. Exam showed unchanged positive Spurling and compression testing; decreased left shoulder range with grinding/clicking/tenderness of rotator cuff; positive Tinel's and Phalen's. X-rays of shoulders showed AC arthritis without fractures; X-rays of cervical spine showed C5-7 cages with screw fixation and questionable fusion. It was reported the patient had recently completed a rehab program for alcohol abuse. Report of 6/20/14 from the provider noted the patient with unchanged chronic neck and upper back symptoms with numbness in both arms. Exam showed tenderness to cervical spine with muscle spasm; decreased cervical range in flex/ext/rotation of 30/10/45 degrees; positive cervical compression and shoulder depression testing. Diagnoses include s/p ACDF at C5-7 for herniated disc s/p 3 epidural steroid injections; left shoulder sprain/strain/ supraspinatus tendinosis; subscapularis bursitis; right shoulder sprain/strain; left elbow and bilateral hand sprain/strain/ rule out CTS/tendonitis. Treatment included PT, MRI of cervical spine; refill of medications; and the patient to continue TTD (unaccommodated significant restrictions). Request(s) for MRI Cervical Spine, Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY, and Physical Therapy two to three times a week for six weeks, Bilateral Shoulder and

Left Elbow 18 QTY were not medically necessary on 7/29/14 while citing guidelines and criteria.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI, Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 172, 177.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 171-171, 177-179.

Decision rationale: This patient sustained an injury to her neck, bilateral upper extremities (elbows, wrists, hands) from repetitive work on 12/16/12 while employed by [REDACTED], Risk Management, Workers' Compensation. The Request(s) under consideration include; MRI Cervical Spine, Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY, and Physical Therapy, two to three times a week, for six weeks, Bilateral Shoulder and Left Elbow 18 QTY. Diagnoses include cervical disc degeneration. Conservative care has included: medications, physical therapy, cervical epidural steroid injections (9/26/13) without substantial relief, and modified activities/rest. Per reports from the provider, the patient has chronic continued neck, bilateral shoulders/arm pain. The exam showed unchanged positive Spurling and compression testing, decreased left shoulder range with grinding/clicking/tenderness of rotator cuff, positive Tinel's and Phalen's. The X-rays of shoulders showed AC arthritis without fractures, X-rays of cervical spine showed C5-7 cages with screw fixation and questionable fusion. It was reported the patient had recently completed a rehab program for alcohol abuse. Report of 6/20/14 from the provider noted the patient with unchanged chronic neck and upper back symptoms with numbness in both arms. Exam showed tenderness to cervical spine with muscle spasm, decreased cervical range in flex/ext/rotation of 30/10/45 degrees, positive cervical compression and shoulder depression testing. The Diagnoses include status post (s/p) Anterior Cervical Discectomy and Fusion (ACDF) at C5-7 for herniated disc s/p 3 epidural steroid injections, left shoulder sprain/strain/ supraspinatus tendinosis, subscapularis bursitis, right shoulder sprain/strain, left elbow and bilateral hand sprain/strain/ rule out CTS/tendonitis. Treatment included: Physical Therapy (PT), MRI of cervical spine, refill of medications, and the patient to continue Temporary Total Disability (TTD) (unaccommodated significant restrictions). Request(s) for MRI Cervical Spine was not medically necessary on 7/29/14. Symptoms and clinical findings have remained unchanged for this 2012 injury without new acute trauma, red-flag conditions, documented failed conservative trial, or flare-up of chronic symptoms and diagnoses already established to support for an updated imaging study. Per ACOEM Treatment Guidelines for the Neck and Upper Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states; criteria for ordering imaging studies include, emergence of a red flag, physiologic evidence of tissue insult, neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, and electro diagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are

sufficient evidence to warrant imaging studies if symptoms persist, however, review of submitted medical reports, including report from providers have not adequately demonstrated the indication for repeating the MRI of the Cervical spine, nor identify any specific acute change in clinical findings to support this imaging study. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI Cervical Spine is not medically necessary and appropriate.

Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 173-174.

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

Decision rationale: Request(s) for Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY was not medically necessary on 7/29/14. Physiotherapy 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 physical therapy (PT) treatment already rendered including milestones of increased range of motion (ROM), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached, and the patient striving to reach those goals. The Physiotherapy two times a week for six weeks, Neck, Bilateral Upper Extremity 12 QTY is not medically necessary and appropriate.

Physical Therapy two to three times a week for six weeks, Bilateral Shoulder and Left Elbow 18 QTY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 173-174.

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

Decision rationale: Request(s) for Physical Therapy two to three times a week for six weeks, Bilateral Shoulder and Left Elbow 18 QTY was not medically necessary on 7/29/14. 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 work 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 9-10 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 symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 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 two to three times a week for six weeks, Bilateral Shoulder and Left Elbow 18 QTY is not medically necessary and appropriate.