

Case Number:	CM14-0057336		
Date Assigned:	07/09/2014	Date of Injury:	11/20/2012
Decision Date:	08/13/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	04/25/2014

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 Occupational Medicine 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 59 year old male who was injured on 11/20/2012. The mechanism of injury is unknown. The patient underwent a spinal decompression at C5-C7 on 11/07/2013, revision on 07/18/2013 and posterior spinal fusion on 01/29/2013. He has been treated conservatively with 22 sessions of physical therapy. Diagnostic studies reviewed include electromyography on 03/12/2014 revealed mild slowing at the left wrist medial nerve. Progress report dated 02/27/2014 indicates the patient presented with left arm symptoms. He reported numbness to the thumb and medial forearm that is constant and unchanged. He is unable to lift, push, or pull greater than 10 pounds. Objective findings on exam revealed the flexion of the cervical spine is 5 degrees with posterior neck pain at the end of range of motion; extension is 16 degrees; right side bending is 30 degrees and left side bending is 25 degrees; and bilateral rotation is 30 degrees with noted strain in the bilateral upper trapezius. The muscle strength of flexor is 4+/5; abductors 4+/5; external rotator 4+/5; upper trapezius is 4+/5, and lower trapezius is 3+/5. It is noted that bilateral shoulders active range of motion is 85 percent normal in elevation, scaption, and reaching behind. The left shoulder passive range of motion through flexion is 170 degrees, abduction is 150 degrees, external rotation at 90 degrees is 90 degrees, and internal rotation at 90 degrees is 60 degrees. There is noted decreased cervical lordosis and both scapulas are in abduction with anterior scapular tilt. There is moderate tenderness in the bilateral upper trapezius, levator scapulae, and incision at C5-C7 junction, and moderate to severe tenderness in the left rhomboid major/minor. There is noted slight incision/adhesion over the C6-C7 junction and lightness (left worse than right) in the pectoralis major. He has positive upper limb tension test median nerve at 90 degrees abduction with wrist flexion at 75 degrees, and elbow extension at 45 degrees. There is noted diminished left C5 sensation. It is noted that the claimant is making gradual progress with increased functional use of left upper extremity. He has decrease in pain

after recent flare up. The claimant presents with status post loss of cervical range of motion to turn head comfortably to drive, look up, or down, limited bilateral upper extremity strength, with left upper extremity radiculopathy, and posterior cervical muscles spasms. Diagnoses are cervical radiculopathy, cervical dysphagia, cervical postlaminectomy syndrome, and cervical spondylosis, cervicgia, and muscle weakness. He was recommended therapeutic exercises twice a week for 12 weeks, hot and cold packs, laser/light therapy. He has been recommended to have an EMG/NCV Prior utilization review dated 04/21/2014 states the request for additional physical therapy 2x/6wks cervical spine is not certified as there is a lack of documented functional improvement, cervical spine x-ray is certified and referral to ortho hand specialist is certified as medical necessity has been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY 2X/6WKS CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES-Neck & Upper Bac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 26. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Physical Therapy.

Decision rationale: According to MTUS guidelines, 24 visits of physical therapy, over 16 weeks in a 6 month treatment period, are recommended after cervical fusion. In this case the patient is status post left C5-6 laminoforaminotomy and C5-7 fusion on 11/7/13 followed by intraoperative I&D one week later for postoperative infection. It is not clear from review of the provided records how many post-operative therapy visits that the patient has completed. It appears that at least 12 were approved. Physical therapy notes are provided for the 7th and 8th visits in early February 2014, though functional improvement is not clearly demonstrated. Functional improvement from physical therapy is not addressed elsewhere. Therefore, medical necessity is not established for additional physical therapy as number of completed visits and response to therapy is unclear. The request is not medically necessary and appropriate.

CERVICAL SPINE X-RAY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Radiography.

Decision rationale: According to MTUS and ODG guidelines cervical spine X-ray may be indicated when significant pathology is suspected in the acute or chronic setting. In this case the patient is status post cervical spine fusion on 11/7/13 followed by postoperative infection. However, several postoperative X-rays have already been performed including one on 2/21/14. While an additional X-ray may be indicated, no specific rationale is provided in the available medical records. Medical necessity is not established, the request is not medically necessary and appropriate.

REFERRAL TO ORTHO HAND SPECIALIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES- Forearm, Wrist, & Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 503.

Decision rationale: MTUS guidelines recommend specialist referral when the diagnosis is complicated or care may benefit from additional expertise. However, in this case there is no specific rationale provided for referral to a hand specialist. Medical necessity is not established, the request is not medically necessary and appropriate.