

Case Number:	CM15-0007576		
Date Assigned:	01/22/2015	Date of Injury:	09/15/2010
Decision Date:	03/19/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/13/2015

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, Arizona

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 53-year-old male with a reported injury on 08/15/2010. The mechanism of injury was not provided. The injured worker's diagnoses were noted to include cervical spondylosis, cervical spine spondylosis with myelopathy, cervical spine herniated nucleus pulposus, cervical disc degeneration, cervical disc discitis, cervical spinal stenosis, an unspecified disc disorder of the lumbar spine, low back syndrome, and sprain of the lumbar region. His past treatments have included activity modification, medication, physical therapy, chiropractic therapy, and the use of a TENS unit. His diagnostic testing has included cervical spine x-ray on 02/06/2014, which reported no changes in the plate position and a positive fusion mass; an MRI of the left shoulder on 02/20/2014, which reported acromioclavicular joint arthritis with no rotator cuff tendonitis; an MRI of the cervical spine on 04/17/2014, which reported C2-3 herniated nucleus pulposus with HIZ, C3-4 herniated nucleus pulposus with HIZ, and left paracentral bulge causing moderate central and left foraminal stenosis, C4-5 mild herniated nucleus pulposus causing mild central and left foraminal stenosis, and C5-7 ACDF; and an undated MRI of the lumbar spine, which reported facet arthropathy at L3-4, L4-5, and L5-S1 bilaterally with neural foraminal stenosis at L3-4, L4-5, and L5-S1. His surgical history was noted to include an anterior cervical discectomy and fusion at C5-6 and C6-7 on 03/11/2013. The injured worker was evaluated on 09/15/2014 for orthopedic re-evaluation. He complained of spasms to the cervical spine with numbness on the fingertips of his right hand. He continued to complain of lower back pain with radiation down the right leg and cramping in the lumbar spine. His medications were noted to include Lorcet 10/650 mg and Soma 350 mg. Physical

examination of the cervical spine revealed 25 degrees of flexion, 50 degrees of extension with significant spasm, bending 10 degrees bilaterally, rotation 20 degrees to the left and 30 degrees to the right. There was a well healed anterior scar. The injured worker had spasms with range of motion of the cervical spine. Elevation of bilateral shoulders measured 170 degrees with the left shoulder elevation causing spasms in the cervical spine. Impingement sign was positive on the left. Strength measured 5/5. There was tenderness at the bilateral paracervical region in midline with 2+ spasms of the paracervical and trapezius muscles bilaterally. There was slight tenderness of the left anterior shoulder. There was numbness to light touch in the right hand and thumb, index, and middle finger. Evaluation of the lumbar spine revealed 70 degrees of flexion with moderate pain and 5 degrees of extension with moderate pain. Side bending measured 10 degrees bilaterally with rotation measuring 20 degrees bilaterally. There was tenderness midline at L4-5. Motor exam measured 5/5 bilaterally. There was tenderness in the lumbar spine in the midline and paralumbar region with 2+ spasm. Straight leg raise was positive on the right. The injured worker remained on modified duty. The clinician's treatment plan included physical therapy 2 times a week for 6 weeks for the left shoulder, the injured worker was to stop tramadol and continue with patches and cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy; lumbar spine, 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99-100.

Decision rationale: The request for physical therapy; lumbar spine, 2 times per week for 4 weeks is not medically necessary. The patient complained of spasms in the cervical spine. The California MTUS Chronic Pain Guidelines recommend physical therapy in the amount of 8 to 10 visits over 4 to 8 weeks, plus active self-directed home physical medicine. The provided documentation did not indicate benefit from previous physical therapy, there was no documentation of a home exercise program or that current functional deficits could not be addressed with an independent home exercise program. As such, the requested service is not supported. Therefore, the request for physical therapy; lumbar spine, 2 times per week for 4 weeks is not medically necessary.