

<b>Case Number:</b>	CM15-0189906		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	08/15/2010
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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 46 year old female, who sustained an industrial injury on 8-15-2010, resulting in pain or injury to the low back. A review of the medical records indicates that the injured worker is undergoing treatment for status post posterior fusion L4-L5 and L5-S1, left shoulder superior labral anterior and posterior (SLAP) tear with impingement, right shoulder partial rotator cuff tear, chronic pain syndrome, probable depression, bilateral ulnar neuropathy at the elbows, possible reflex sympathetic dystrophy or Complex Regional Pain Syndrome (CRPS) of the right upper extremity, and MRI report of narrowing of the neural foramina bilaterally, left greater than right at C5-C6 and an extruded disc at C6-C7. On 7-22-2015, the injured worker reported constant neck pain, frequent headaches, bilateral radiating arm pain and numbness, bilateral shoulder pain, and bilateral hand pain, popping in both shoulders and elbows, and swelling in both hands and wrists. The single submitted Primary Treating Physician's report dated 7-22-2015, noted the injured worker's current medications were Trazadone, Clonazepam, Stresscare, Tylenol PM, and vitamins. The cervical spine examination was noted to show normal cervical lordosis, tenderness to palpation of the bilateral trapezii, and neck pain with range of motion (ROM). Prior treatments have included cervical epidural steroid injections (ESIs), bilateral shoulder Cortisone injections, spinal fusion in 2014, facet injections, and Norco, noted to be ineffective. The treatment plan was noted to include cervical facet injections as she responded favorable to previous injections, consultation with an upper extremity specialist, and physical therapy to address her symptoms. The injured worker's work status was noted to be permanent and stationary. The documentation provided for review did not include any documentation of previous physical therapy sessions. The request for authorization dated 8-11-2015, requested 12 sessions of Physical Therapy, 2x6 weeks of the cervical spine as outpatient. The Utilization Review (UR) dated 8-19-2015, non-certified the request for 12 sessions of Physical Therapy, 2x6 weeks of the cervical spine as outpatient.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **12 Physical Therapy, 2x6 weeks of the Cervical Spine as Outpatient: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The 12 Physical Therapy, 2x6 weeks of the Cervical Spine as Outpatient is not medically necessary and appropriate.