

<b>Case Number:</b>	CM15-0197890		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	09/04/1999
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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 53 year old female who sustained an industrial injury on September 04, 1999. A recent primary treating office visit dated September 14, 2015 reported subjective complaint of "dizziness and tingling and numbness to the left side." The patient continues to have tingling and numbness in the bilateral upper extremity, the right lower extremity and the left side of her face. She also complains of having poor balance. She stated she just had a car accident about two weeks previously that had increased her pain and discomfort. Neurologist's complete exam noted normal clinical findings in motor strength and sensation with unremarkable normal EMG (electrodiagnostic) studies. The assessment found the worker: status post cervical anterior decompression and fusion February 2015; status post anterior cervical decompression and fusion prior to 2005; status post anterior posterior lumbar fusion with hardware removal done in the early 2000's. There is note of recent nerve conduction study with normal findings and the plan of care is with recommendation for pool therapy followed by land therapy, utilize cane, and pain management referral. Previous treatment to include: activity modification, medication, physical therapy, stretching and home exercises, bone growth stimulator, surgery. On September 24, 2015 a request was made for physical therapy session treating the cervical spine 12 session that were denied by Utilization Review on September 29, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy of the cervical spine, two (2) times a week for six (6) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Neck & Upper Back.

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

**Decision rationale:** Review indicates the patient is s/p ACDF on 2/10/15, over 9 months past and outside the rehabilitation period of surgical recovery with chronic guidelines applicable. The patient noted involvement in a recent car accident; however, a recent neurologist's evaluation noted normal EMG without neurological deficits on clinical exam. It is not clear how many therapy visits have been completed; however, submitted reports have not demonstrated any functional improvement from treatment rendered to support for the request of 12 PT visits. 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 to date; 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 for this 1999 chronic injury. 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 Physical Therapy of the cervical spine, two (2) times a week for six (6) weeks is not medically necessary and appropriate.