

<b>Case Number:</b>	CM15-0081842		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	02/04/2004
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 64 year old female, who sustained an industrial injury on February 4, 2004. She reported neck pain, back pain radiating to the lower extremities, bilateral shoulder pain and bilateral wrist pain. The injured worker was diagnosed as having cervical discopathy with radiculitis, bilateral shoulder impingement syndrome, bilateral wrist sprain with probable carpal tunnel syndrome, grade II spondylolisthesis of the lumbosacral spine, neural compression with lumbar radiculitis, right greater than left and lumbar disc displacement. Treatment to date has included diagnostic studies, conservative care, medications and work restrictions. Currently, the injured worker complains of continued neck pain, back pain radiating to the lower extremities, bilateral shoulder pain and bilateral wrist pain. The injured worker reported an industrial injury in 2004, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on February 18, 2015, revealed continued pain as noted. Physical therapy of the cervical and lumbar spine and radiographic imaging of the lumbar and cervical spine were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 sessions of physical therapy for the lumbar & cervical spine: 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): 98,99.

**Decision rationale:** MTUS Guidelines recommend up to 8-10 sessions of physical therapy as adequate for the chronic conditions that this individual have. Given the remote date of injury, it is reasonable to assume that prior physical therapy has been trialed and there is no evidence of lasting benefits. A few sessions may be reasonable to renew instruction in appropriate activities, but on an exception basis, the medical necessity of a course of therapy to exceed what is Guideline recommended is not evident. The request for 12 sessions of physical therapy for the lumbar and cervical spine is not supported by Guidelines and is not medically necessary.

**Cervical spine MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck - Magnetic Resonance Imaging.

**Decision rationale:** This individual has had a prior cervical MRI without results implicating impending neurological compromise. MTUS Guidelines do not address this issue of repeat spinal MRI testing. ODG addresses this issue and does not recommend repeat testing unless there is a definitive change in symptoms or neurological function. The requesting physician documents ongoing pain complaints with radiation, but there are no neurological changes and it is not documented that the subjective complaints are new or recently changed to a significant degree. Under these circumstances, the repeat cervical spine MRI is not supported by Guidelines and is not medically necessary.