

Case Number:	CM14-0215843		
Date Assigned:	01/05/2015	Date of Injury:	03/11/2004
Decision Date:	03/03/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 patient is a 55 year old female with a work injury 3/11/04. The diagnoses include cervical and lumbar radiculopathy. She has shoulder pain, low back and neck pain. Under consideration are requests for physical therapy 3 x 4 weeks of bilateral low back area-neck and cane -left shoulder. There is a 7/2/14 follow up from a secondary physician that states that the patient presents with chronic cervical and lumbar spine pain. On exam there is spasm in the cervical and lumbar spines with decreased range of motion of flexion/extension. Decreased sensation is noted in C6, C7, L4, L5, S1 dermatomes bilaterally. Muscle strength is 4/5 on flexion and extension of knees bilaterally against gravity. Cervical MRI images revealed C5-6 and C6-7 decrease of intervertebral disc space with disc protrusion in posterior direction. There is bilateral neural foraminal narrowing at these levels. The lumbar MRI revealed complete collapse at L4-5 with disc protrusion in posterior direction. Level L3-4 is positive for a very significant and practice complete collapse of the intervertebral disc with disc material in the posterior direction. There is very significant facet hypertrophy and bilateral neural foraminal narrowing at the L4-5 and to less degree at L3-4. The documentation states that the patient is a candidate for a cervical discectomy and fusion and lumbar interbody fusion. Per documentation a 10/2/14 office visit revealed spine and bilateral shoulder pain 9/10. On exam the patient could early heel walk and toe walk without difficulty. There were multiple spasms and trigger points noted. The Spurling's test was positive on the left. Exam of the lumbar spine revealed spasms and trigger points with a positive bilateral straight leg raise. Muscle strength was intact everywhere except

for muscles around the shoulders 4/5 and reduced grip strength. Sensation was normal and reflexes were symmetric. The patient was referred to PT and a cane was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

physical therapy 3x4 weeks of bilateral low back area- neck: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Physical therapy 3x4 weeks of bilateral low back area- neck is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines only recommend up to 10 visits for this condition. The request as written exceeds this recommended number. Additionally, it is not exactly clear how much prior physical therapy and the outcome of this therapy for both the low back and neck. Without this information, additional therapy cannot be recommended and the request for physical therapy 3 x 4 of bilateral lower back area-neck is not medically necessary.

Cane-left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg

Decision rationale: Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot

orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker.