

<b>Case Number:</b>	CM15-0100111		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	09/01/2012
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 63 year old female, who sustained an industrial injury on 09/01/2012. According to a progress report dated 04/23/2015, chief complaints included neck pain and bilateral elbow pain. Treatment to date has included neurodiagnostic studies, repeat electromyography, MRI of the cervical spine and left elbow, cervical myelogram, post myelogram computed tomography scan and injection to the elbows. Neck pain was located at the base of the skull. The left middle, ring and small fingers would go numb. Pain occasionally radiated down the left arm. There was pain in the right and left elbow. Both thumbs were sore off and on. Diagnoses included cervical spondylosis with stenosis C4-C5, C5-C6 and C6-C7, possible mild left C7 radiculopathy, left carpal tunnel syndrome, mild common extensor tendinosis left elbow, mild to moderate tendinosis of distal attachment of the triceps tendon left elbow and mild degenerative changes of the capitellum left elbow. An agreed medical examiner recommended that future medical care should include physical therapy, injections and possible surgery. She was seen by a spine surgeon who felt that the injured worker was a candidate for cervical discectomy and fusion surgery. The provider noted that the injured worker has had no physical therapy addressing the cervical spine. Recommendations included physical therapy for the cervical spine. Currently under review is the request for physical therapy for the cervical spine 3 x 6.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Physical Therapy Cervical Spine 3 x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2). 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request cannot be certified. Therefore, the requested treatment is not medically necessary.