

Case Number:	CM15-0099999		
Date Assigned:	06/02/2015	Date of Injury:	06/29/2010
Decision Date:	06/30/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	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 was a 47 year old male, who sustained an industrial injury, June 29, 2010. The injured worker previously received the following treatments psychological services, Wellbutrin, Buspar, Ativan, Hydrocodone, Carisoprodol, Omeprazole, EEG (electroencephalogram) electrodiagnostic studies, cervical spine MRI, cervical spine x-rays, lumbar spine x-rays, pelvis x-rays, cervical hardware removal July 18, 2014, random toxicology laboratory studies negative for any unexpected findings, daily exercise program and stretches. The injured worker was diagnosed with postoperative status, anterior cervical partial corpectomy at C5, C6 and C7, followed by decompression of the spinal cord and neural foramen as well as anterior cervical fusion and instrumentation, cervical spine fusion at C5-C6 and C6-C7 with intact grafting per CT scan on January 17, 2013, lumbar spine fusion of L4-L5 January 16, 2012 and January 17, 2013. According to progress note of March 6, 2015, the injured workers chief complaint was lumbar spine pain. The injured worker rated the pain at 4 out of 10, with radiation of pain into the left leg. The leg feels heavy and cold. The cervical spine pain was rated at 5 out of 10, with weakness in the hands. The injured worker admitted that the medications helped with the pain. The injured worker admitted to having a CT scan of the lumbar spine and lumbar spine, sine last visit. The physical exam noted diffuse tenderness of the lumbar paraspinal muscle. There was pain over the hardware bilaterally. There was moderate facet tenderness over the L3- L4 and L4-L5, left greater than the right. The Kemps test was positive bilaterally. Farfan's test was positive bilaterally. There was decreased range of motion in all plans. The physical exam did not include the cervical spine. The treatment plan included physical therapy for the cervical and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the cervical spine, three times a week for eight weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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 goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The request is in excess of these recommendations per the California MTUS. There is no explanation why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. Therefore the request is not medically necessary.

Physical Therapy for the cervical and lumbar spine, three times a week for eight weeks:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines
Page(s): 26.

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 goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The request is in excess of these recommendations per the California MTUS. There is no explanation why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. Therefore the request is not medically necessary.