

Case Number:	CM13-0045080		
Date Assigned:	12/27/2013	Date of Injury:	05/20/2013
Decision Date:	02/27/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old who reported injury on 05/20/2013. The mechanism of injury was stated to be motor vehicle accident. The patient was noted to have mid neck, mid back, low back, and right shoulder pain. The patient was noted to have pain with burning, throbbing sensation of the left plantar foot. The patient was noted to be seen by an orthopedist on 09/25/2013 where she received a subacromial injection. The patient's diagnoses were noted to include posttraumatic stress disorder and strain of the thoracic spine. The request was made for an NCS (nerve conduction study) of the bilateral lower extremities, physical therapy evaluation for the lumbar spine, therapeutic exercises, physical therapy for the lumbar spine, manual therapy for the lumbar spine, ultrasound for the lumbar spine, and iontophoresis.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCS (nerve conduction study) of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve Conduction Studies (NCS).

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines does not recommend NCS as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The patient was noted to have decreased sensation to light touch over the bilateral lower legs, right lateral dorsum of the foot, and left medial dorsum of the foot. The clinical documentation submitted for review indicated the patient had signs and symptoms of radiculopathy which would not support the necessity for nerve conduction study. The request for an NCS of the bilateral lower extremities is not medically necessary.

Physical therapy evaluation, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 7, and 98 - 99. Page(s): 7, 98-99.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that physical medicine with passive therapy 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. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The patient was noted to continue a home exercise program. Objectively, the patient was noted to have motor strength of 5/5, proximal and distal and sensation to light touch was subjectively decreased over the bilateral lower legs, right lateral dorsum of the foot, and left medial dorsum of the foot. The patient was noted to have a negative bilateral straight leg raise and negative bilateral extensor hallucis longus with a normal gait. The patient was noted to have active range of motion that was limited in all planes. The clinical documentation submitted for review indicated the patient was undergoing a home exercise program. There was a lack of documentation indicating the efficacy and the functional benefit. The patient should be well versed in a home exercise program and it was documented she was participating in one. There is a lack of documentation indicating functional deficits to support the necessity for the requested evaluation. The request for physical therapy evaluation, lumbar spine is not medically necessary.

Therapeutic exercises, twice weekly, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 7, and 98 - 99. Page(s): 7, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Section, page 47, and the Physical Medicine Section, page 99 - 99. Page(s): 47, 99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that physical medicine with passive therapy 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. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. The patient was noted to continue a home exercise program. Objectively, the patient was noted to have motor strength of 5/5, proximal and distal and sensation to light touch was subjectively decreased over the bilateral lower legs, right lateral dorsum of the foot, and left medial dorsum of the foot. The patient was noted to have a negative bilateral straight leg raise and negative bilateral extensor halluc longus with a normal gait. The patient was noted to have active range of motion that was limited in all planes. The clinical documentation submitted for review indicated the patient was undergoing a home exercise program and there was a lack of documentation indicating the patient's functional deficits as was as the necessity for continued therapy. The patient should be well versed and was participating in a home exercise program. There was a lack of documentation indicating the functional benefit that had been received with the therapy. There was a lack of documentation indicating the duration of care being requested. The request for therapeutic exercises, twice weekly, lumbar spine is not medically necessary.

Physical therapy, twice weekly, to the lumbar spine.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 7, and 98 - 99. Page(s): 7, 98-99.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that physical medicine with passive therapy 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. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis and 8-10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The patient was noted to continue a home exercise program. Objectively, the patient was noted to have motor strength of 5/5, proximal and distal and sensation to light touch was subjectively decreased over the bilateral lower legs, right lateral dorsum of the foot, and left medial dorsum of the foot. The patient was noted to have a negative bilateral straight leg raise and negative bilateral extensor halluc longus with a normal gait. The patient was noted to have active range of motion that was limited in all planes. The clinical documentation submitted for review indicated the patient was undergoing a home exercise program and there was a lack of documentation indicating the patient's functional deficits as was as the necessity for continued therapy. The patient should be well versed and was participating in a home exercise program. There was a lack of documentation indicating the functional benefit that had been received with the therapy. There was a lack of documentation indicating the duration of care being requested There was a lack of documentation indicating the duration of care being requested. The request for physical therapy, twice weekly, to the lumbar spine is not medically necessary.

Manual therapy, twice weekly, to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 7, and 98 - 99. Page(s): 7, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Section, pages 58 - 59. Page(s): 58-59.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment beyond 4-6 visits should be documented with objective improvement in function. The clinical documentation submitted for review indicated the patient had no soft tissue swelling, but had tenderness at the lumbosacral junction. However, there was a lack of documentation indicating the patient had pain caused by a musculoskeletal condition. There was a lack of documentation indicating the duration of care being requested. The request for manual therapy, twice weekly, to the lumbar spine is not medically necessary.

Iontophoresis, twice weekly, to the lumbar spine.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Iontophoresis Section.

Decision rationale: Official Disability Guidelines do not recommend iontophoresis for the low back or upper back. There is a lack of documentation indicating the necessity for the request. Additionally, there is a lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations and to indicate the duration of care being requested. The request for Iontophoresis, twice weekly, to the lumbar spine is not medically necessary.