

<b>Case Number:</b>	CM13-0051882		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	02/01/2009
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas and New York. 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/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 injured worker is a 53 year old male who reported an injury on 02/01/2009 due to an unspecified mechanism of injury. Electrodiagnostic studies performed on 07/09/2013 showed normal conduction studies for both upper and lower extremity nerves, and normal electromyography of muscles of upper and lower extremities, innervated by C4 through T1 and L3 through S1 nerve roots. On 08/23/2013, he reported shoulder pain, stiffness and low back pain rated at an 8/10. He also reported left knee and neck pain. Examination of the lumbar spine revealed positive tenderness at the lumbar paravertebral, buttocks, sciatic notches and sacroiliac joints bilaterally. Range of motion showed flexion to 50 degrees and extension to 10 degrees, lateral bending and trunk rotation were 15 degrees bilaterally. Sensory was diminished in the L5 distribution, and straight leg raises were positive on the left. Examination of bilateral knees revealed tenderness to the patellofemoral, medial/lateral joint lines. Range of motion of the left knee was 0-125 degrees, 5/5 motor strength bilaterally, positive patellar pain on compression bilaterally, and sensation was intact. His diagnoses included knee arthralgia, cervical spine degenerative disc disease, and lumbar/lumbosacral disc degeneration, Ganglion of tendon sheath, knee meniscus tear, and lumbar myofascial sprain/strain. Prior treatments included 6 sessions of physical therapy. The treatment plan was for additional physical therapy for the lumbar spine two times a week for four weeks and one cortisone injection to the left knee with ultrasound guidance. The request for authorization form was signed on 09/19/2013. The rationale for treatment was not specified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy for the lumbar spine two times per week for four weeks:**

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:** The request for additional physical therapy for the lumbar spine two times per week for four weeks is non-certified. Per a clinical note dated 09/25/2013, the injured worker stated he had attended 6 physical therapy sessions with some benefit. The California MTUS guidelines state that physical medicine is recommended for 9-10 visits over 8 weeks. Treatment frequency should be faded. Based on the clinical documentation provided, there is evidence that the injured worker still has some functional deficits. However, there is a lack of documentation regarding objective functional improvement with the prior therapy sessions. Evidence of efficacy is needed to warrant the request for additional physical therapy. In addition, the request for 8 additional sessions would exceed guideline recommendations and is not supported. Given the above, the request for additional physical therapy for the lumbar spine two times per week for four weeks is not medically necessary and appropriate.

**One cortisone injection to the left knee with ultrasound guidance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Corticosteroid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Corticosteroid injections.

**Decision rationale:** The request for one cortisone injection to the left knee with ultrasound guidance is non-certified. Examination of bilateral knees performed on 08/23/2013 revealed tenderness to the patellofemoral, medial/lateral joint lines. Range of motion of the left knee was 0-125 degrees, 5/5 motor strength bilaterally, positive patellar pain on compression bilaterally, and sensation was intact. The CA MTUS/ ACOEM Guidelines state that corticosteroid injections for the knee are not routinely recommended. In addition, the Official Disability Guidelines state that ultrasound guidance must be used, and findings of symptomatic severe osteoarthritis that interferes with functional activities must be documented. The injured worker was noted to have a normal symmetric gait during the examination. With the clinical information provided, the injured worker does not have evidence of osteoarthritic pain or that his knee pain is interfering with functional activities. The request is not supported by the guideline recommendations. Given the above, the request for one cortisone injection to the left knee with ultrasound guidance is not medically necessary and appropriate.

