

Case Number:	CM13-0064913		
Date Assigned:	01/03/2014	Date of Injury:	09/01/2011
Decision Date:	04/04/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/12/2013

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 & 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:

According to the records made available for review, this is a 48 year old female with a 9/1/11 date of injury, and status post left knee diagnostic arthroscopy, chondroplasty, synovectomy, lysis of adhesions, and removal of loose body 2/28/13. At the time of request for authorization for physical therapy 3 times 4 left knee, EMG of the bilateral lower extremities, and NCV of the bilateral lower extremities, there is documentation of subjective (pain in the bilateral knees and low back pain with radiating numbness and tingling down her lower extremities) and objective (restricted range of motion in the left knee, weakness in the quadriceps and hamstrings, positive straight leg raise, and decreased sensation in the dorsum of the left foot) findings, imaging findings (MRI Lumbar Spine (9/3/13) report revealed at L3-4, there is a central focal disc protrusion that abuts the thecal sac, at L4-5, there is facet hypertrophy that produces bilateral neuroforaminal narrowing, and at L5-S1, there is grade 1 lytic 5.9mm spondylolisthesis of L5 and combined with a disc protrusion and facet hypertrophy, there is bilateral neuroforaminal narrowing and impingement on the L5 exiting nerve roots), current diagnoses (s/p unspecified left knee arthroscopy and lumbar sprain/strain with radiculopathy), and treatment to date (activity modification, physical therapy, acupuncture, chiropractic care, knee cortisone injections, and medications). Report indicates that the patient has had 39 sessions of postoperative physical therapy. 9/9/13 electrodiagnostic report revealed a subtle right S1 radiculopathy that may be suggestive of a left femoral mononeuropathy or upper lumbar radiculopathy. Postoperative physical therapy guidelines for frequency as well as treatment period are exceeded. In addition, there is no documentation that the etiology of the radicular symptoms is not explained by MRI and documentation of an interval injury or progressive neurologic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times 4 left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: MTUS post surgical treatment guidelines identifies up to 12 visits of post-operative physical therapy over 12 weeks and post-surgical physical medicine treatment period of up to 6 months. Within the medical information available for review, there is documentation of a diagnosis of s/p unspecified left knee arthroscopy and lumbar sprain/strain with radiculopathy. In addition, there is documentation of status post left knee diagnostic arthroscopy, chondroplasty, synovectomy, lysis of adhesions, and removal of loose body 2/28/13 and 39 post-operative physical therapy sessions completed to date, which exceeds guidelines. Furthermore, given documentation of a 2/28/13 date of surgery, post-surgical physical medicine treatment period exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for physical therapy 3 times 4 left knee is not medically necessary.

EMG 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 (ODG).

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, documentation of an interval injury or progressive neurologic findings is needed for a repeat electrodiagnostic study. Within the medical information available for review, there is documentation of diagnoses of s/p unspecified left knee arthroscopy and lumbar sprain/strain with radiculopathy. In addition, there is documentation of a previous electrodiagnostic study showing subtle right S1 radiculopathy and may be suggestive of a left femoral mononeuropathy or upper lumbar radiculopathy. However, given documentation of imaging findings (MRI identifies that at L4-5, there is facet hypertrophy that produces bilateral neuroforaminal narrowing, and at L5-S1, there is grade 1 lytic 5.9mm spondylolisthesis of L5 and combined with a disc protrusion and facet hypertrophy, there is bilateral neuroforaminal narrowing and impingement on the L5 exiting nerve roots), there is no documentation that the etiology of the radicular symptoms is not explained by MRI. In addition,

there is no documentation of an interval injury or progressive neurologic findings. Therefore, based on guidelines and a review of the evidence, the request for EMG of the bilateral lower extremities is not medically necessary.

NCV 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 (ODG).

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, Electrodiagnostic studies.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, documentation of an interval injury or progressive neurologic findings is needed for a repeat electrodiagnostic study. Within the medical information available for review, there is documentation of diagnoses of s/p unspecified left knee arthroscopy and lumbar sprain/strain with radiculopathy. In addition, there is documentation of a previous electrodiagnostic study showing subtle right S1 radiculopathy and may be suggestive of a left femoral mononeuropathy or upper lumbar radiculopathy. However, given documentation of imaging findings (MRI identifies that at L4-5, there is facet hypertrophy that produces bilateral neuroforaminal narrowing, and at L5-S1, there is grade 1 lytic 5.9mm spondylolisthesis of L5 and combined with a disc protrusion and facet hypertrophy, there is bilateral neuroforaminal narrowing and impingement on the L5 exiting nerve roots), there is no documentation that the etiology of the radicular symptoms is not explained by MRI. In addition, there is no documentation of an interval injury or progressive neurologic findings. Therefore, based on guidelines and a review of the evidence, the request for NCV of the bilateral lower extremities is not medically necessary.