

<b>Case Number:</b>	CM15-0101321		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	04/10/2014
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 51 year old female patient who sustained an industrial injury on 04/10/2014. The accident was described as while working the normal duty in a elementary school setting the worker was called to the front office to assist with a discipline issue of a kindergarten student who had caused problems. She reports having had approached the student asking what had happened; the boy began running inside the office and she ran after him to avoid him getting out of the office and ended with resulting pain. She was evaluated and underwent radiography scan. A report of first illness dated 10/09/2014 reported the patient with subjective complaint of having headaches, visual disturbance, burning and popping sensation in ears, and right knee pain. Objective findings showed the patient using a walker, with knee brace, and positive swelling of the right knee. There is right knee patellofemoral pain, tenderness of the popliteal fossa, and tenderness along the medial and lateral joint lines of the right knee. She is diagnosed with: cervical spine strain/sprain; right elbow contusion/blunt trauma; and lumbar sprain/strain. A primary treating office visit dated 12/17/2014 reported subjective complaints of right knee, right elbow, cervical spine and headaches. Objective findings showed there was 3 plus spasm and tenderness to the bilateral paraspinal muscles from C2-4 and bilateral suboccipital muscles. An axial compression test was positive bilaterally for neurological compromise along with a shoulder depression test positive bilaterally. The elbows showed with positive spasm, tenderness to the right lateral epicondyle and right olecranon. A Cozen's test was found positive on the right. Diagnostic impression noted the patient with tear of the medial meniscus of the right knee; cervical disc herniation without myelopathy; lateral epicondylitis of the right elbow, and right olecranon bursitis. The patient has completed 2 of 12 authorized physical medicine session. She was prescribed: topical compound creams.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy three (3) times a week for four (4) weeks for the Right Knee, Cervical Spine, Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy three (3) times a week for four (4) weeks for the Right Knee, Cervical Spine, Lumbar Spine is not medically necessary and appropriate.

**EMG/NCS for the Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Chapter 12, "Low Back Complaints", Table 12-8, Electro diagnostics, page 309 to clarify nerve root dysfunction.

**Decision rationale:** There were no correlating neurological deficits defined nor conclusive imaging identifying possible neurological compromise. MRI of the lumbar spine had no identified disc herniation, canal or neural foraminal stenosis demonstrated. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, and entrapment neuropathy, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome. The EMG/NCS for the Bilateral Lower Extremities is not medically necessary and appropriate.

**EMG/NCS for the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck & Upper Back, Special Studies and Diagnostic and Treatment Considerations, pages 177-178.

**Decision rationale:** Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with peripheral neuropathy or entrapment syndrome, radiculopathy, foraminal or spinal stenosis, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any entrapment syndrome or cervical radiculopathy only with continued diffuse tenderness without neurological deficits without specific consistent myotomal or dermatomal correlation to support for the electro diagnostics. There was no documented failed conservative trial for this chronic injury without new injury or acute changed findings. The EMG/NCS for the Bilateral Upper Extremities is not medically necessary and appropriate.