

<b>Case Number:</b>	CM15-0188677		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	08/12/2015
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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 26 year old male, who sustained an industrial injury on 8-12-15. The injured worker was diagnosed as having blisters, epidermal loss [second degree burn] of multiple sites; ulnar nerve injury-neuritis; lumbar sprain-strain-contusion-radiculitis; left calf 1st degree burn. Treatment to date has included occupation therapy consult; physical therapy; medications. Currently, the PR-2 notes dated 8-14-15, the provider documents "The patient presents with patient states a propane tank blew-up and burned his upper-lower left arm and lower left leg... singed his face and back of head...cannot move arm...pain scale 10 out of 10, self-reported." The provider continues with a physical examination: "In mild distress. No increased work of breathing or sings of respiratory distress. All lung fields clear to auscultation bilaterally. Normal rate and rhythm, normal S1 and S2, without gallops or rubs. No murmur, Normal PMI, no thrills. Second degree burns of multiple sites." The treatment plan was to start the injured worker on Tramadol 50mg 1 tablet 3 daily and Silver Sulfadiazine 1% external cream (Silvadene) to affected areas twice daily. The PR-2 notes dated 8-17-15 indicates the injured worker returns, still in pain. Continues to need his Tramadol for pain. The plan was for burn dressing to be changed and x-rays of the left elbow complete minimum 3 views. No medication was prescribed at this visit, but to return in two days for follow-up. PR-2 dated 8-19-15 indicated the injured worker returns for a follow-up and reports "There is a tingling 4th and 5th digit". The provider notes "occasional ulnar tingling. Exacerbating factors include direct pressure." On physical examination the provider documents "left elbow range of motion full, neurovascular function intact; positive Tinel's at the cubital tunnel. Skin healing well; no signs of infection." The treatment plan included an occupational therapy referral due to contusion of

the left ulnar nerve; physical therapy 3 times a week for 2 weeks; home dressing with Silvadene cream. PR-2 notes dated 8-21-15 indicate the injured worker presented for follow-up and dressing change. While getting dressing change, injured worker complained of left side of face being numb, very weak and dizzy. Squad called, IV started; aspirin given PO. Advised to go to ER but refused and would not sign AMA form. Advised to go to ER if altered mental status and injured worker agreed. Dressing changed. PR-2 notes dated 8-24-15 note injured worker returns for follow-up visit for burns to left upper arm and lower leg. The provider documents "Patient states he feels a little better on lower leg...upper arm very sore...last time patient was in we called paramedics and was told to go to ER." Injured worker did not go to ER. The provider notes "Patient states that he is only about 15% better. He is experiencing numbness in his 4th and 5th fingers. He is running out of home Silvadene supplies." On physical examination, the provider notes "Left elbow-skin with healing burns, no erythema or discharge; left 4th and 5th fingers with decreased sensation to light touch; left lower extremity with 2nd degree burns; healing well except for one area which is not healed but wound is clean, no erythema or discharge. Gait - slowed." There are no notes that occupational therapy consult or that physical therapy was completed up to this date. A Request for Authorization is dated 9-15-15. A Utilization Review letter is dated 8-28-15 and non-certification was for Additional PT 3x2 6 Sessions for the Left Arm (Ulnar Nerve). A request for authorization has been received for Additional PT 3x2 6 Sessions for the Left Arm (Ulnar Nerve).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Additional PT 3x2 6 Sessions for The Left Arm (Ulnar Nerve): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The 26 year old patient complains of pain in the lower back radiating to buttocks and left leg; left arm and hand pain, numbness and tingling; and right rib cage pain; as per progress report dated 08/28/15. The request is for ADDITIONAL PT 3x2 6 SESSIONS FOR THE LEFT ARM (ULNAR NERVE). The RFA for this case is date 08/24/15, and the patient's date of injury is 08/12/15. Diagnoses, as per progress report dated 08/28/15, included second degree burn on the left arm, first degree burn on the left calf, left elbow sprain/strain, left ulnar neuritis, lumbar sprain/strain with radiculitis, lumbar spine contusion, and lumbar spine radiculitis. The left upper arm and left lower leg pain is rated at 8/10, as per progress report dated 08/21/15. The patient is temporarily totally disabled, as per progress report dated 08/28/15. MTUS Chronic Pain Management Guidelines 2009, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are

recommended." In this case, a patient referral form, dated 08/24/15, states that 6 sessions of physical therapy are being requested. In the progress report with the same date, the treater indicates that the patient would complete physical therapy to treat ulnar nerve contusion on 08/25/15. The treater is also requesting for 6 additional sessions in the same progress report. Neither the progress reports nor the Utilization Review denial letter document the number of physical therapy sessions completed until now and their impact on patient's pain and function. The treater does not indicate why the patient has not transitioned to a home exercise regimen. MTUS only allows for 8-10 sessions of physical therapy in non-operative cases, and the treater's request for 6 additional sessions will exceed that limit. Hence, the request IS NOT medically necessary.