

Case Number:	CM15-0199200		
Date Assigned:	10/14/2015	Date of Injury:	02/05/2014
Decision Date:	11/20/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/09/2015

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 59 year old male, who sustained an industrial injury on 2-05-2014. The injured worker was diagnosed as having lumbar radiculopathy, hand pain, lumbar facet syndrome, and shoulder pain. Treatment to date has included diagnostics, arthroscopic left shoulder surgery 2-05-2014 with post-operative physical therapy, and medications. Currently (9-03-2015), the injured worker complains of lower backache, left upper extremity pain, and left shoulder pain, "unchanged since last visit" and rated 5 out of 10, along with left thumb pain. He reported a "stable" pain level and was happy with current pain medications. He denied any radiation of pain to his upper or lower extremities. His activity level remained the same and sleep quality was "poor". He was currently working full time. Current medications included Tramadol and Ibuprofen, noting allergies to Norco and Oxycodone. Exam of the lumbar spine noted "restricted" range of motion with extension limited by pain but normal flexion, spasm and tenderness in the bilateral paravertebral muscles with palpation, positive lumbar facet loading bilaterally, and negative straight leg raise. Exam of the left hand noted tenderness to palpation over the base of the left thumb (greater than right thumb) and some bony enlargement squaring at the base of the bilateral thumbs. Motor exam noted strength of all muscles 5 of 5 and sensory exam noted decreased light touch sensation over the L4 and L5 dermatomes on the left. Reflexes noted 2+ knee jerk bilaterally, ankle jerk 2+ on the right and 0 on the left. The treating physician noted that after magnetic resonance imaging of the lumbar spine, "we will consider appropriate interventional procedures in hopes of alleviating both pain and function". Neurodiagnostic studies of the lower extremities would be requested to rule out lumbar radiculopathy versus

peripheral nerve entrapment. The requested physical therapy was to include range of motion, stretching, strengthening, and home exercise program. The treatment plan included physical therapy for the low back and left thumb x12 and electromyogram and nerve conduction studies of the bilateral lower extremities. On 9-15-2015, Utilization Review modified the requested physical therapy to x6 and non-certified the requested electromyogram and nerve conduction studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, low back and left thumb: 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), Low back, Lumbar & Thoracic (Acute & Chronic), Forearm, Wrist and Hand (Acute & Chronic) - Physical therapy guidelines.

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

Decision rationale: Review indicates the request for PT was modified to 6 sessions. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment for this chronic February 2014 injury. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy, low back and left thumb is not medically necessary and appropriate.

EMG 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), Low back, Lumbar & Thoracic (Acute & Chronic) - EMGs (electromyography), Nerve conduction studies (NCS).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There were no neurological deficits defined or conclusive imagings identifying possible neurological compromise. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, entrapment syndrome, medical necessity for EMG and NCV have not been established. Submitted reports have not demonstrated any radicular symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome. Submitted reports have not demonstrated any correlating symptoms and clinical findings to suggest any lumbar radiculopathy or entrapment syndrome with negative SLR and intact 5/5 motor strength without specific consistent myotomal correlation to support for these electrodiagnostic studies. The EMG Bilateral lower extremities is not medically necessary and appropriate.

NCV Bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There was no neurological deficits defined or conclusive imaging identifying possible neurological compromise. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, entrapment syndrome, medical necessity for EMG and NCV have not been established. Submitted reports have not demonstrated any radicular symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome. Submitted reports have not demonstrated any correlating symptoms and clinical findings to suggest any lumbar radiculopathy or entrapment syndrome with negative SLR and intact 5/5 motor strength without specific consistent myotomal correlation to support for these electrodiagnostic studies. The NCV Bilateral lower extremities is not medically necessary and appropriate.