

<b>Case Number:</b>	CM14-0106212		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	12/10/2010
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 59-year-old female who reported an injury on 12/10/2010 due to a slip and fall. The injured worker reportedly sustained an injury to her left lower extremity and developed compensatory injuries of the right hip, right wrist, and low back. The injured worker's treatment history included bilateral meniscectomies, patellofemoral chondroplasty, total knee arthroplasty, physical therapy, and activity modifications. The most recent clinical evaluation was dated 01/20/2014. It was documented that the injured worker had ongoing left knee and right hand pain complaints. Physical findings included surgical scar on the left knee with restricted range of motion and an antalgic gait. The injured worker's diagnoses included knee joint pain, a knee sprain, complex regional pain syndrome of the lower extremity, knee effusion, knee osteoarthritis, hip pain, piriformis syndrome, trochanteric bursitis, and chronic pain syndrome. The injured worker's treatment recommendations included continued medications. A request was made for physical therapy, electrodiagnostic studies, a right wrist steroid injection, and rental of a stationary bicycle. However, no justification for the request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 Times a Week for 6 Weeks for Left Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The requested Physical Therapy 2 Times a Week for 6 Weeks for Left Knee is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation submitted for review does not indicate that the injured worker is participating in any type of home exercise program for the left knee. There is no recent clinical documentation to support the request. Although a short duration of physical therapy would be indicated in the clinical situation described in the chart note dated 01/20/2014, the requested 12 treatments are excessive. As such, the requested Physical Therapy 2 times a week for 6 weeks for the left knee is not medically necessary or appropriate.

**EMG on Right Upper Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck & Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** The requested EMG on Right Upper Extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies of the upper extremities when a more precise delineation between radiculopathy and peripheral nerve involvement is required to assist with treatment planning. The clinical documentation submitted for review did not provide a recent assessment of the injured worker's deficits to support that there is possible nerve root impingement or peripheral nerve impingement. Therefore, it is unclear how an electrodiagnostic study would contribute to the injured worker's treatment plan. Furthermore, there is no documentation that the injured worker has had any conservative therapy to assist with symptom relief. As such, the requested EMG for the right upper extremity is not medically necessary or appropriate.

**NCS on Right Upper Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck & Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** The requested NCS for the right upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies of the upper extremities when a more precise delineation

between radiculopathy and peripheral nerve involvement is required to assist with treatment planning. The clinical documentation submitted for review did not provide a recent assessment of the injured worker's deficits to support that there is possible nerve root impingement or peripheral nerve impingement. Therefore, it is unclear how an electrodiagnostic study would contribute to the injured worker's treatment plan. Furthermore, there is no documentation that the injured worker has had any conservative therapy to assist with symptom relief. As such, the requested NCS for the right upper extremity is not medically necessary or appropriate.

**Right Wrist Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-266.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

**Decision rationale:** The requested Right Wrist Steroid Injection is not medically necessary or appropriate. There was no recent clinical documentation to support deficits that would require or benefit from a corticosteroid injection. The evaluation dated 01/20/2014 did not provide any wrist deficits to support the need for a steroid injection. Furthermore, there was no documentation that the injured worker has undergone any type of conservative treatment prior to the requested invasive procedure. The American College of Occupational and Environmental Medicine recommends a period of conservative treatment prior to injection therapy. The clinical documentation fails to identify any period of immobilization or active therapy that has failed to assist with symptom resolution. As such, the requested Right Wrist Steroid Injection is not medically necessary or appropriate.

**Stationary Bicycle Rental- 90 Days- for Left Lower Extremity: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Knee Chapter-Exercise Equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Durable Medical Equipment (DME).

**Decision rationale:** The requested Stationary Bicycle Rental- 90 Days- for the left lower extremity is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend durable medical equipment that is customarily used to serve a medical purpose and is not beneficial to the injured worker in the absence of injury or illness. The clinical documentation submitted for review does not provide any evidence that the injured worker has failed to respond to a self-managed, self-directed home exercise program and requires additional equipment. The clinical documentation submitted for review did not include a recent assessment of deficits that would require this type of equipment. Furthermore, as the

requested equipment would be supportive of the patient in the absence of injury and illness, it would not be supported by guideline recommendations. As such, the requested Stationary Bicycle Rental- 90 Days- for the left lower extremity is not medically necessary or appropriate.