

Case Number:	CM13-0066916		
Date Assigned:	01/03/2014	Date of Injury:	08/14/2012
Decision Date:	05/15/2015	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/19/2013

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 43 year old male, who sustained an industrial injury on 8/14/12. He sustained bilateral leg injuries and a head injury. The injured worker was diagnosed as having status post closed head injury, cervical spine sprain/strain with right upper extremity radiculopathy, thoracic spine sprain/strain with lower extremity radiculopathy, status mid shaft left femur fracture with internal fixation, status post open tibial plateau fracture with internal fixation, left hip strain, status post left ankle fracture with internal fixation. Treatment to date has included physical therapy, oral medications, multiple surgeries and home exercise program. Currently, the injured worker states improved mobility with physical therapy. The injured worker states increased mobility and weight bearing following physical therapy. The treatment plan included additional 6 physical therapy visits, additional home care assistance, transportation services for all medical appointments and follow up with orthopedic surgeon, (EMG) Electromyogram studies, ultrasound diagnostic study of left shoulder and (MRI) magnetic resonance imaging of lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 2 X Per Week X 3 Weeks (6 Sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: The patient presents with pain and weakness in his neck, mid back, lower back and upper/lower extremities. The patient is s/p left femur IMN, left tibial plateau ORIF and left ankle ORIF on 09/05/12 and right pilon ORIF on 09/11/12. The request is for 6 sessions of physical therapy. The utilization review letter on 11/25/13 indicates that the patient has had 17 sessions of physical therapy without benefit. Regarding work status, the treater states that the patient is TTD. The current request of physical therapy appears outside of post-surgical time frame as surgery was more than 6 months from the request date. For non-post-operative therapy treatments, MTUS guidelines page 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. In this case, prior treatment appears to have failed and there is no explanation as to what can be accomplished with additional therapy. There is no discussion regarding the patient's home exercise program and why the patient is unable to do the necessary home exercises. Furthermore, the requested 6 sessions combined with 17 already received for non-post-op therapy treatments exceed what is allowed per MTUS for this kind of condition. The request IS NOT medically necessary.

An MRI Of The Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation low back chapter, MRI.

Decision rationale: The patient presents with pain and weakness in his neck, mid back, lower back and upper/lower extremities. The patient is s/p left femur IMN, left tibial plateau ORIF and left ankle ORIF on 09/05/12 and right pilon ORIF on 09/11/12. The request is for MRI of the lumbar spine. X-rays of the pelvis, left hip, left femur, bilateral tibia, bilateral tibias/fibula and bilateral ankles from 12/05/12 demonstrates multiple fractures requiring open reduction/internal fixation surgery. Regarding work status, the treater states that the patient is TTD. ACOEM Guidelines, Chapter 12, page 303, states, "Unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging on patients who do not respond well to treatment and who would consider surgery as an option." For this patient's now chronic condition, ODG Guidelines provides a thorough discussion. ODG, under its low back chapter, recommends obtaining an MRI for uncomplicated low back pain with radiculopathy after 1 month of conservative therapy, sooner if there is severe or progressive neurological deficit. In this case, the treater does not explain why MRI of the lumbar spine is being requested. There is no documentation that patient has had prior MRI of the lumbar spine. One of the diagnoses is lower back pain with radiculopathy in the left lower extremity. It appears that the patient has failed conservative care, including physical therapy, aqua therapy and medications. The 02/10/14 QME's report indicates that decreased sensation in the left L4 and

L5 nerve root distribution and positive straight leg raising (SLR) test. Given that the patient has had lower back pain with radicular symptoms in despite of conservative treatment and the clinical findings of positive SLR test, the request IS medically necessary.

EMG/NCV Of The Left Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation low back chapter, Nerve conduction studies.

Decision rationale: The patient presents with pain and weakness in his neck, mid back, lower back and upper/lower extremities. The request is for EMG/NCV of the left lower extremity. Regarding work statue, the treater states that the patient is TTD. For EMG, ACOEM guidelines page 303 support EMG and H-reflex tests to determine subtle, focal neurologic deficit. However, EMG is not recommended for clinically obvious radiculopathy per ODG guidelines. Regarding Nerve conduction studies, ODG guidelines under Low Back chapter: Nerve conduction studies states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." ODG for Electrodiagnostic studies (EDS) states, "NCS which are not recommended for low back conditions, and EMGs which are recommended as an option for low back." In this case, the treater does not explain why EMG/NCV of the left lower extremity is being requested. There is no documentation that patient has had prior EMG/NCV studies. The diagnosis is lower back pain with radiculopathy in the left lower extremity. The 02/10/14 QME's report indicates that decreased sensation in the left L4 and L5 nerve root distribution and positive straight leg raising test. Given that the patient has not had this test performed in the past, the patient's continuing radiating symptoms and clinical findings, the request IS medically necessary.

A Diagnostic Ultrasound Of The Right Shoulder: 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), Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation shoulder chapter, Ultrasound.

Decision rationale: The patient presents with pain and weakness in his neck, mid back, lower back and upper/lower extremities. The request is for a diagnostic ultrasound of the right shoulder. Regarding work statue, the treater states that the patient is TTD. MTUS and ACOEM guidelines do not mention Ultrasound treatment. ODG guidelines, under Shoulder Chapter, Ultrasound Topic, recommends diagnostic ultrasound, stating "The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator

cuff tears, although ultrasound may be better at picking up partial tears. Ultrasound also may be more cost-effective in a specialist hospital setting for identification of full-thickness tears. (Dinnes, 2003)." In this case, the treater does not discuss shoulder symptoms or examination findings other than listing periscapular strain and impingement syndrome with a history of clavicle fracture. The guidelines require some suspicion of internal derangement such as rotator cuff or labral tear to consider an MRI. Such suspicions are not documented either via symptoms or exam findings. The request IS NOT medically necessary.