

Case Number:	CM15-0163631		
Date Assigned:	08/31/2015	Date of Injury:	03/06/2013
Decision Date:	11/09/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/20/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 42-year-old male, with a reported date of injury of 03-06-2013. The diagnoses include lumbar spine sprain and strain with left leg radicular pain, lumbar stenosis, facet osteoarthritis, right wrist sprain and strain with history of scaphoid fracture, status post left knee arthroscopy, left knee osteoarthritis, right knee sprain and strain, and sleep loss. Treatments and evaluation to date have included Neurontin, Norco, Tylenol with codeine, Vicodin, and Xanax. The diagnostic studies to date were not indicated. The progress report dated 07-21-2015 indicates that the injured worker had lumbar spine, right wrist, left knee, and right knee symptoms. The objective findings include tenderness to palpation of the left medial joint line, decreased active range of motion of the left knee, tenderness to palpation of the lumbar spine, lumbar flexion at 45 degrees, lumbar extension at 15 degrees, tenderness to palpation of the right wrist, decreased active range of motion of the right wrist, decreased sensation of the right wrist, and positive Tinel's. The treatment plan included physical therapy to treat flare-up of the left knee, right wrist, and lumbar spine; and electrodiagnostic studies of the right upper extremity to rule out carpal tunnel syndrome. The injured worker was instructed to return usual and customary duties on 07-21-2015. The treating physician requested physical therapy for the right wrist two times a week for three weeks; physical therapy for the lumbar spine two times a week for three weeks; physical therapy for the left knee two times a week for three weeks; electromyography and nerve conduction velocity (EMG-NCV) of the right upper extremity. On 08-06-2015, Utilization Review (UR) non-certified the request for physical therapy for the right wrist two times a week for three weeks; physical therapy for the lumbar spine two times a week for three weeks; physical therapy for the left knee two times a week for three weeks; electromyography and nerve conduction velocity (EMG-NCV) of the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x3 for lumbar spine: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient has completed previous physical therapy sessions. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional 6 PT sessions. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

EMG/NCV of right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electromyography (EMG) and Nerve Conduction Velocities (NCV).

Decision rationale: The request for diagnostic testing EMG/NCV for the right upper extremity is not medically necessary. According to the California MTUS/ACOEM Guidelines, electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of

radiculopathy. In this case, there are no signs of neurologic issues that would indicate a peripheral neuropathy based on the physical exam. In addition, there is no documentation of any objective clinical findings or any neurological deficits to support the requested NCV of the right upper extremity. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

Physical therapy 2x3 for left knee: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient has completed previous physical therapy sessions. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional 6 PT (2x3) sessions. Medical necessity for the requested additional PT for the left knee has not been established. The requested service is not medically necessary.

Physical therapy 2x3 for right wrist: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient has completed previous physical therapy sessions. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional 6 PT (2x3) sessions. Medical necessity for the requested additional PT for the right wrist has not been established. The requested service is not medically necessary.