MAXIMUS Federal Services

Case Number:	CM15-0175922		
Date Assigned:	09/17/2015	Date of Injury:	06/08/2015
Decision Date:	10/20/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/08/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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, who sustained an industrial injury on 6-8-15. He reported left elbow pain. The injured worker was diagnosed as having intraarticular minimally displaced left radial head fracture, minimally displaced fracture of the coronoid process in the left elbow, and rule out ulnar neuropathy at cubital tunnel. Treatment to date has included 8 sessions of physical therapy, a home exercise program, use of a Dynasplint, and medication. The treating physician noted physical therapy provided improvement in range of motion. Physical examination findings on 8-5-15 included left elbow flexion to 130 degrees, extension -15 degrees, pronation to 70 degrees, and supination to 80 degrees. No triggering of the digits was noted. Currently, the injured worker complains of pain in the left radial head with numbness of the dorsal and lateral elbow and forearm to his left ring finger. On 8-10-15, the treating physician requested authorization for 8 additional physical therapy sessions and electromyogram or nerve conduction study of the cervical spine- bilateral upper extremities. On 8-17-15, the requests were modified or non-certified. Regarding physical therapy, the utilization review (UR) physician modified the request to certify 4 physical therapy sessions. Regarding electromyogram or nerve conduction studies, the UR physician noted there were "no signs and symptoms of ulnar neuropathy, symptoms improvement after physical therapy sessions and home exercises, and the evidence-based guidelines recommendations, proceeding with an electromyogram or nerve conduction study of the cervical spine-bilateral upper extremities does not appear to be medically necessary."

IMR ISSUES, DECISIONS AND RATIONALES

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

8 additional physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow, Acute & Chronic, Physical Therapy.

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

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below: Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)-Physical Medicine Guidelines-Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine-Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks-Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)-8-10 visits over 4 weeks-Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.

EMG/NCV of the C/S-bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute & Chronic); Electrodiagnostic studies (EDS) (2015).

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

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.