

Case Number:	CM13-0004397		
Date Assigned:	01/10/2014	Date of Injury:	06/25/2009
Decision Date:	09/25/2015	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	07/29/2013

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 58 year old female, who sustained an industrial injury on 6-25-2009. Diagnoses have included right hip arthritis status post replacement, lumbar sprain with Grade II-III spondylosis L4 on L5 and sacroiliac sprain from antalgic gait. Treatment to date has included transcutaneous electrical nerve stimulation (TENS) unit, sacroiliac injection, physical therapy and medication. According to the progress report dated 5-14-2013, the injured worker was seen for follow up on her bilateral hip sprains and lumbar sprain. She reported benefit from Lidoderm patches on her lumbar spine. She reported that her pain ranged from three to nine out of ten. She reported needing to lay down two to three times per day to relieve her back and hip pain. She reported that physical therapy reduced her pain from nine out of ten to four out of ten. Physical exam revealed tenderness in both hips and thighs. Authorization was requested for physical therapy for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY VISITS FOR THE LUMBAR SPINE ONCE A WEEK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - <https://www.acoempracguides.org/> Low Back, Table 2, Summary of Recommendations, Low Back Disorders.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127.

Decision rationale: This claimant was injured in 2009 with right hip arthritis status post replacement, lumbar sprain with Grade II-III spondylosis L4 on L5 and sacroiliac sprain reportedly from an antalgic gait. Treatment to date has included transcutaneous electrical nerve stimulation (TENS) unit, sacroiliac injection, physical therapy and medication. As of May 2013, there was bilateral hip and lumbar pain. The MTUS does permit physical therapy in chronic situations, but note that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are 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; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: "Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general." A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy was not medically necessary.