

Case Number:	CM14-0190526		
Date Assigned:	11/24/2014	Date of Injury:	03/30/2011
Decision Date:	01/09/2015	UR Denial Date:	10/18/2014
Priority:	Standard	Application Received:	11/14/2014

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 & Rehabilitation and is licensed to practice in North Carolina. 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 53-year-old female who reported injury on 03/30/2011. The mechanism of injury was a fall. The diagnoses included right hip labral tear and chronic greater trochanteric bursitis, left hip compensatory greater trochanteric bursitis, left knee compensatory pain, right wrist carpal tunnel syndrome, and lumbar spine pain. Past treatments were not documented. EMG studies of the bilateral lower extremities were noted to reveal chronic L5 radiculopathy bilaterally. An MRI was noted to show left L4-5 and L5-S1 foraminal narrowing and degenerative changes. The surgical history was not included. The progress note, dated 09/29/2014, noted the injured worker had continued back pain, with no obvious radiculopathy. The physical examination noted stiffness and spasm to the low back, and a positive straight leg raise with no active radiculopathy. Tenderness was noted over the anterior groin, and pain with flexion, internal and external rotation of the hip. Her current medications were not listed. The treatment plan requested 12 sessions of chiropractic care of the lumbar spine, as well as, physical therapy twice a week for 6 weeks for the right hip, left knee, and low back. The Request for Authorization form was submitted for review on 09/29/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

(12) Physical Therapy visits over 6 weeks Lumbar and Right Hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58,99.

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

Decision rationale: The request for (12) Physical Therapy visits over 6 weeks Lumbar and Right Hip is not medically necessary. The injured worker had unmeasured back and hip pain. The California MTUS Guidelines recommend physical therapy to restore flexibility, strength, endurance, function, and range of motion. The guidelines recommend 9 sessions to 10 sessions of physical therapy over 8 weeks and a continuation of active therapy at home as an extension of the treatment process. There is a lack of documentation of functional deficits of the lumbar spine and right hip. There is a lack of documentation of the quality and severity of pain. The request for 12 sessions of physical therapy exceeds the guideline recommendations for an initial and general course of treatment. Given the above, 12 sessions of physical therapy for the lumbar spine and right hip are not indicated or supported by the evidence based guidelines at this time. Therefore, the request is not medically necessary.