

Case Number:	CM14-0200607		
Date Assigned:	12/10/2014	Date of Injury:	08/02/2013
Decision Date:	02/20/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/01/2014

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. 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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

55y/o male injured worker with date of injury 8/2/13 with related left hip and left hand pain. Per progress report dated 11/4/14, it was noted that lumbar spine range of motion was limited to 50% of normal. Extension caused pain to the buttocks. Mild to moderate spasm tenderness and spasm were noted. Straight leg raise was negative bilaterally. Deep tendon reflex was 1+ at the ankle and symmetrical. Motor exam showed diffuse give-way weakness in the entire lower extremity. Sensory exam did not show specific numbness. Range of motion of the hips was full. There was no groin pain. Moderate tenderness was noted about the greater trochanter on the left. Extension caused some pain radiating to the buttocks bilaterally. Treatment to date has included physical therapy and medication management. The date of UR decision was 11/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Exam and treat with Pain Management, possible facet injection at L4-5, L5-S1 bilaterally:
 Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, page 92, 127, and on the

Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic)
Chapter, Office Visits

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 27.

Decision rationale: The California MTUS Guidelines recommend a consultation to aid with diagnosis/prognosis and therapeutic management, recommend referrals to other specialist if a diagnosis is uncertain or exceedingly complex when there are psychosocial factors present, or when, a plan or course of care may benefit from additional expertise. The documentation submitted for review indicates that the injured worker may be a candidate for injection therapy. However, the medical necessity of facet injection at L4-L5, L5-S1 bilaterally cannot be affirmed until after consultation. The request is not medically necessary. It should be noted that the UR physician has certified a modification of the request for pain management exam only.

Continue physical therapy (PT) 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Physical Medicine

Decision rationale: Per MTUS CPMTG, physical medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Per the ODG guidelines: Osteoarthritis and allied disorders (ICD9 715): Medical treatment: 9 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment: 18 visits over 12 weeks. Arthropathy, unspecified (ICD9 716.9): Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment, arthroplasty/fusion, hip: 24 visits over 10 weeks. The documentation submitted for review indicates that the injured worker has previously had physical therapy for the left hip. It is noted that the request was made along with cortisone injection which was indicated for the injured worker's trochanteric bursitis and which was approved. The guidelines only support 1-2 visits post-injection treatment. As the request for 8 physical therapy sessions is in excess of the guidelines, the request is not medically necessary. It should be noted that the UR physician has certified a modification of the request for 2 additional visits of physical therapy.