

Case Number:	CM15-0005647		
Date Assigned:	01/26/2015	Date of Injury:	09/25/2013
Decision Date:	03/13/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/12/2015

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: California
 Certification(s)/Specialty: Emergency 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 53-year-old female, with a reported date of injury of 09/25/2013. The diagnoses include sacroilitis, degenerative lumbar/lumbosacral intervertebral disc disease, lumbosacral strain, low back pain, piriformis syndrome, and right hip labral tear. Treatments have included physical therapy for the low back; an MRI of the right hip on 01/20/2014, which showed possible tear involving the superior lateral labrum, anterior labral tear, and thinning of the articular cartilage of the lateral aspect of the acetabulum; right hip gadolinium joint injection on 01/20/2014; and an MRI of the lumbar spine on 03/13/2014, which showed slight lumbar hyperlordosis and scoliosis, mild to moderate multi-level degenerative disc disease in the lower thoracic and entire lumbar spine, and minimal disc bulges at the lower three lumbar interspaces. The medical report injection was performed per a report dated 11/19/2014 indicates that an outpatient ultra-sound guided was performed. The physical examination showed tenderness to palpation with positive muscle twitch response in the right piriformis, no tenderness to palpation at the right trochanteric bursa, and negative straight leg raise test. The treating physician requested an ultrasound-guided injection to help with the ability to see critical structures. The rationale for the requested physical therapy for the right hip and lumbar spine and functional capacity evaluation was not provided. On 12/17/2014, Utilization Review (UR) denied the request for four (4) physical therapy sessions of unspecified frequency for the right hip and lumbar spine, functional capacity evaluation, and ultrasound-guided injection in the trochanteric bursa. The UR physician noted that no new information was provided regarding the recommendation for physical therapy, the injured worker returned to work without restriction on

11/19/2014, and there was no tenderness to palpation of the bursa and no diagnosis of bursitis. The MTUS Chronic Pain Guidelines and the Non-MTUS Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 4 to the right hip and lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Page 300. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy

Decision rationale: The requested Physical therapy x 4 to the right hip and lumbar spine, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and ODG Treatment in Workers Compensation, ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit. The treating physician has documented tenderness to palpation with positive muscle twitch response in the right piriformis, no tenderness to palpation at the right trochanteric bursa, and negative straight leg raise test and a bursal injection was performed on 11/19/14. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions. The criteria noted above not having been met, Physical therapy to the right hip and lumbar spine is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, 132-139

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7 Page 48.

Decision rationale: The requested functional capacity evaluation, is not medically necessary. "The American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004) Chapter 7, page 137-138 noted that "There is little scientific evidence confirming FCEs predict an individual's actual capacity to perform in the workplace." The treating physician has documented tenderness to palpation with positive muscle twitch response in the right piriformis, no tenderness to palpation at the right trochanteric bursa, and negative straight leg raise test and a bursal injection was performed on 11/19/14. The treating physician has not documented the medical necessity for this evaluation as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Functional capacity evaluation is not medically necessary.

Trochanteric bursa injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip & Pelvis (Acute & Chronic) Injections

Decision rationale: The requested Trochanteric bursa injection is not medically necessary. CA MTUS is silent. ODG Hip & Pelvis (Acute & Chronic) Injections recommends these injections only for severe osteoarthritis. The treating physician has documented tenderness to palpation with positive muscle twitch response in the right piriformis, no tenderness to palpation at the right trochanteric bursa, and negative straight leg raise test and a bursal injection was performed on 11/19/14. The treating physician has not documented the presence of severe hip osteoarthritis. The criteria noted above not having been met, Trochanteric bursa injection is not medically necessary.