

<b>Case Number:</b>	CM15-0133719		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	04/12/2015
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 33 year old male who sustained an industrial injury on 4-12-2015. He developed cumulative trauma affecting the low back, right hip, and right knee. He has reported back pain, right hip pain, and right knee pain and has been diagnosed with lumbar spine sprain strain with radicular complaints, right hip sprain, and right knee sprain strain. Treatment has included medications, medical imaging, and physical therapy. The lumbar examination revealed increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoraco lumbar junction and over the level of L5-S1 facets and right greater sciatic notch with muscle spasms. There was decreased range of motion. There was a positive straight leg raise at 20 degrees on the right. There was a positive Patrick Fabere's test. There was decreased range of motion of the right hip. There was tenderness to palpation along the medial joint line and inferior pole of patella. There was swelling plus 1 noted. There was decreased range of motion to the right knee. The treatment plan included physical therapy and MRI. The treatment request included physical therapy for the right knee, right hip, and low back and MRI of 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 1x4 weeks for right knee, right hip & low back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 474.

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

**Decision rationale:** The patient presents with pain affecting the right knee, right hip, and low back. The current request is for Physical Therapy 1x4 weeks for right knee, right hip, & low back. The treating physician states in the report dated 6/11/15, "At this time, I would like to request authorization for the patient to undergo physical therapy at a rate of once per week for four weeks." (84B) The MTUS guidelines state, "They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process" and MTUS only allows 8-10 sessions of physical therapy. In the records provided for review for this case, the treating physician has not documented how many prior physical therapy sessions the patient has completed and if the patient had any functional improvement with physical therapy. There is no documentation of any recent surgery, flare-up, new injury or new diagnosis that would require additional physical therapy and there is no discussion as to why the patient is not currently able to transition to a home exercise program. The current request is not medically necessary.

**MRI of Lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Indications for imaging - Magnetic resonance imaging.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, MRIs.

**Decision rationale:** The patient presents with pain affecting the right knee, right hip, and low back. The current request is for MRI of the Lumbar Spine. The treating physician states in the report dated 6/11/15, "Additionally, I would like to request authorization for MRI study of the lumbar spine to better assess the root of the patient's complaints." (84B) The ODG guidelines support MRI scans for patients with lower back pain with radiculopathy and other red flags. In this case, the treating physician has documented that the patient has radicular complaints and has not had any previous lumbar MRI scans. The current request is medically necessary.