

<b>Case Number:</b>	CM15-0191951		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	06/13/2014
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 male who sustained an industrial injury on 8-13-14. A review of the medical records indicates he is undergoing treatment for sprain of the hip and thigh on the right with quad injury, as well as sprain of the lumbar region. Medical records (4-13-15- 15 to 8-25-15) indicate ongoing complaints of moderate right leg pain in his anterior thigh to his knee. He also complains of "aching" in his back. No radiation of back pain is noted. He does not complain of numbness. He rates his pain "5 out of 10". The physical exam (8-7-15) reveals tenderness to palpation of the lumbar paravertebral muscles bilaterally. Tenderness is also noted on palpation of the right sacroiliac joint. The right hip is noted to be restricted "with FROM" and is "very painful in quads with hip flexion and abduction". Tenderness is noted of the thigh. Tone is noted to be decreased. Diagnostic studies have included MRIs of the lumbar spine and right thigh, Doppler ultrasounds of the right lower extremity, and bilateral EMG-NCV of bilateral lower extremities. Treatment has included medications and, at least, 24 sessions of physical therapy from 2011 to 7-7-15. The injured worker is noted to be on work restrictions, consisting of no repetitive squatting and no repetitive walking on uneven ground. The treating provider indicates that if the work restrictions cannot be accommodated, he should be considered medically temporarily totally disabled. The injured worker noted effects of his symptoms on activities of daily living include difficulty with personal care, lifting, walking, stairs, sitting, reaching and grasping, kneeling, bending, squatting, traveling, social activities, and concentrating. The treatment recommendations include a steroid injection into the right rectus femoris muscle to help reduce inflammation and progress his function, as well as 12 sessions of physical therapy to "improve strength. The utilization review (9-2-15) indicates the

requests for authorization include physical therapy 2 times a week for 3 weeks for the right lower extremity and physical therapy 1 time a week for 12 weeks for the right lower extremity and back. The decision modified the request and approved 6 sessions of physical therapy for the right lower extremity.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy 1 time a week for 12 weeks right lower extremity, back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

**Decision rationale:** Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy one time per week times 12 weeks to the right lower extremity and back is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are sprain hip and thigh NOS quad injury right; and sprain lumbar region. Date of injury is August 13, 2014. Request for authorization is August 7, 2015. According to an August 7, 2015 progress note, subjective complaints include right leg pain and anterior thigh pain and back pain. Pain score is 5/10. The injured worker completed six out of six physical therapy sessions. Objectively, there is tenderness to palpation over the paraspinal muscles bilaterally and tenderness at the SI joints. There was a peer-to-peer conference between the utilization reviewer and the treating provider. The treating provider agreed physical therapy was not needed to the lower back. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and the peer-to-peer conference with agreement physical therapy was not necessary for the lower back. Physical therapy one time per week times 12 weeks to the right lower extremity and back is not medically necessary.