

<b>Case Number:</b>	CM15-0200955		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	05/23/2013
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: 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 61 year old female, who sustained an industrial injury on 5-23-2013. The injured worker was being treated for depressive disorder, chronic pain syndrome, bilateral hip pain, degeneration of lumbosacral intervertebral disc, and low back pain. Treatment to date has included diagnostics, functional restoration program, home exercise program, and medications. Currently (9-15-2015), the injured worker complains of right hip flexor pain, "which is new" for her. Pain was rated 4 out of 10 (unchanged from 7-28-2015 when she reported "a bad week of pain last week", noting some driving and more activity than usual). She was tearful during the visit, particularly when discussing work. Her work status was "disabled". It was documented that she has not had any physical therapy since the functional restoration program. Medications included Ambien CR, Cyclobenzaprine, Cytomel, Estradiol, Lyrica, Oxycodone, Progesterone, Zofran, and Zoloft. Physical exam noted lumbar range of motion "normal", extension less than 10 degrees. Functional Restoration Program note (5-01-2015) noted that the injured worker was in her third week of treatment. The completion date for the program was not specified. The treatment plan included physical therapy, 1x6, for the pelvic floor, non-certified by Utilization Review on 9-30-2015.

### 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 6 weeks (pelvic floor): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Wein: Capmbell-Walsh Urology, 9th ed. Chapter 63 - Conservative Management of Urinary Incontinence: Behavioral and Pelvic Floor Therapy, Urethral and Pelvic Devices.

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

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has pain with a presumptive diagnosis of osteitis pubis. There are no specific objective deficits in the sacral or pelvic region which would benefit from manual therapy. Medical necessity for the requested physical therapy is not established. The requested therapy services are not medically necessary.