

Case Number:	CM14-0210436		
Date Assigned:	12/23/2014	Date of Injury:	12/21/2013
Decision Date:	02/27/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/15/2014

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
 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 patient is an injured worker with a history of lumbar back and lower extremity strain and sprain. The agreed medical examination report dated October 28, 2014 documented the doctor's first report of occupational injury dated 12/28/13 documented the date of injury of 12/21/13. The patient claims he was clocking out for lunch and felt pain to whole left leg and hip. He complains of mild to moderate pain in left leg and hip, aggravated with movement. Diagnoses were hip osteoarthritis and trochanteric bursitis. The progress report dated 1/30/14 documented bilateral shoulder pain, bilateral wrist pain, lumbar spine pain, bilateral hip pain, bilateral knee pain, and bilateral ankle foot pain. Physical therapy two times a week for four weeks was prescribed. The progress report dated 7/24/14 documented the recommend for physical therapy PT two times a week for four weeks. Diagnoses were lumbar spine sprain and strain with left leg radiation and left leg numbness, left hip sprain and strain, left sacroiliac joint sprain and strain, left knee sprain and strain, and left ankle sprain and strain. On January 30, 2014, the patient presented with complaints of pain in the shoulders, arms, hands, wrists, back, hips, knees, ankles and feet, and was prescribed physical therapy two times per week for four weeks. The agreed medical examination report dated October 28, 2014 documented the patient states that he started to have physical therapy to his lower back, hips and knees approximately four months ago. He states that the therapy consists of range of motion exercises, electrostimulation and massage, two times per week. He states that he last received therapy approximately three weeks ago. He states that the therapy provided temporary relief. Physical examination was documented. Lumbosacral spine had expression of discomfort. There is no gross deformity noted. The iliac crests are parallel. The

patient is able to toe and heel walk easily. He is noted to ambulate without an antalgic gait. The straight leg raising maneuver is negative to 90 degrees bilaterally in both sitting and supine positions. The Lasegue and Fabere maneuvers are negative bilaterally. Muscle strength testing measures 5/5 in all tested lower extremity motor groups. Sensation is intact to pinprick and light touch testing in all dermatomes. The progress report dated October 30, 2014 documented left leg pain. Physical examination demonstrated lumbosacral spasm. Left lower extremity tenderness. The patient had low back pain with left leg radiation. Diagnoses were lumbar back and lower extremity strain and sprain. Treatment plan included physical therapy two times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times per week for 4 weeks for the lumbar/left leg/hip: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain, Suffering and the Restoration of Function Chapter, page 114 and the ODG Knee and Leg Chapter; Low Back Chapter; Hips and Pelvis Chapter and Ankle and Foot Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine; Definitions Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment Official Disability Guidelines (ODG) Preface Physical Therapy Guidelines.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six-visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. The agreed medical examination report dated October 28, 2014 documented that physical therapy two times a week for four weeks was prescribed on 1/30/14. The progress report dated 7/24/14 documented the recommendation for physical therapy PT two times a week for four weeks. The agreed medical examination report dated October 28, 2014 documented the patient states that he started to have physical therapy approximately four months ago. The patient states that the therapy consists of range of motion exercises, electrostimulation and massage, two times per week. He states that he last received therapy approximately three weeks ago. The progress report dated October 30, 2014 documented a request for additional physical therapy two times a week for four weeks. Medical records indicate that the number of physical therapy treatments have already exceeded MTUS guideline recommendations. Clinically significant improvement in activities of daily living, reduction in

work restrictions, or reduction in the dependency on continued medical treatment were not documented in the 10/30/14 progress report. No exceptional factors were noted. Per ODG guidelines, patients should be formally assessed after a six-visit clinical trial to evaluate whether PT physical therapy has resulted in positive impact, prior to continuing with physical therapy. The request for 8 additional physical therapy treatments exceeds ODG guideline recommendations, without the recommended documentation of functional improvement or exceptional factors. Therefore, the request for Physical Therapy 2 times per week for 4 weeks for the lumbar/left leg/hipis not medically necessary.