

Case Number:	CM15-0175450		
Date Assigned:	09/16/2015	Date of Injury:	06/24/2014
Decision Date:	10/20/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/05/2015

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 40 year old, female who sustained a work related injury on 6-24-14. The diagnoses have included lumbar herniated nucleus pulposus, right bursitis and right gluteus medius tear. Treatments have included physical therapy (greater than 24 sessions), home exercises, lumbar epidural steroid injection, right hip surgery, right hip injections and oral medications. Current medications include Soma and Percocet. In the progress notes dated 8-18-15, the injured worker reports continuing lower back pain. She also reports right gluteal discomfort. She is limping. Upon physical exam, she has tenderness to palpation over lumbar spine. She has pain with flexion and extension of lumbar spine. She has paraspinal spasm. She has lumbar spine and gluteal weakness. Physical therapy note dated 7-20-15 relates that she has "80% of normal" movement and strength in right hip and low back pain. She is currently not working. The treatment plan includes a request for authorization for physical therapy. In the Utilization Review, dated 8-31-15, the requested treatment of physical therapy 2 times a week for 6 weeks was non-certified due to CA MTUS guidelines not being met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 2 times a week for 6 weeks, right glut/quad strengthening: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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) Pain section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times six weeks to the right glut-quad for strengthening 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 lumbar HNP; and right gluteus medias tear. Date of injury is June 24, 2014. Request for authorization is August 24, 2015. The injured worker is status post right hip arthroscopy with iliotibial band release. The utilization review states the injured worker received 24 physical therapy sessions. The physical therapy documentation is incomplete, but contains documentation indicating the injured worker continues a home exercise program and is 80% improved. According to an August 18, 2015 handwritten, illegible progress note, subjective complaints include low back pain. Objectively there is tenderness to palpation over the paraspinal muscle groups. There is no documentation demonstrating objective functional improvement by the treating provider. There are no compelling clinical facts indicating additional physical therapy is clinically warranted. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement, no documentation with the total number of physical therapy sessions to date and no compelling clinical documentation indicating additional physical therapy over the recommended guidelines is clinically indicated, physical therapy two times per week times six weeks to the right glut-quad for strengthening is not medically necessary.