

<b>Case Number:</b>	CM15-0063394		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	10/19/2012
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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  
 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 33 year old female, who sustained an industrial injury on 10/19/12. She reported left hip pain, bilateral shoulder and left leg discomfort. The injured worker was diagnosed as having left hip trochanteric bursitis with radiculopathy. Treatment to date has included physical therapy, ibuprofen and oral steroids. Currently, the injured worker complains of left leg pain. Upon physical exam, tenderness is noted over the trochanter. The treatment plan included prescription for Flector patches and Voltaren cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY X 12 SESSIONS LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface, Physical Therapy Guidelines. ODG Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (PT).

**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. 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. 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) Low Back - Lumbar & Thoracic (Acute & Chronic) recommends 10 physical therapy visits for lumbar sprains and strains. MRI magnetic resonance imaging of the lumbar spine report dated July 7, 2014 documented an unremarkable MRI the lumbar spine. The physical therapy report dated 10/28/14 documented the completion of 12 visits of physical therapy. The utilization review letter dated 12/24/2014 documented the certification of 12 visits of physical therapy for the cervical and lumbar spine. Twelve additional visits of physical therapy for the lumbar spine were requested on 3/13/15. Per ODG, 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. No functional improvement with latest course of physical therapy was documented in the submitted medical records. The request for 12 additional visits of physical therapy for the lumbar spine exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy is not medically necessary.