

<b>Case Number:</b>	CM13-0070913		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	06/25/2009
<b>Decision Date:</b>	09/25/2015	<b>UR Denial Date:</b>	07/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2013

### 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: Texas, Florida, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 female, who sustained an industrial injury on 6-25-09. The injured worker has complaints of back and hip pain. The diagnoses have included right hip arthritis status post replacement; left hip arthritis, post replacement; lumbar sprain with grade 11-111 spondylolisthesis L4 on L5 and sacroiliac sprain from antalgic gait. Treatment to date has included lidoderm patches; transcutaneous electrical nerve stimulation unit; physical therapy and hip replacement. The request was for six physical therapy visits for right hip, once a week as an outpatient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the Right Hip (6-sessions, once a week for 6-weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** This claimant was injured in 2009 and has back and hip pain. The diagnoses have included right hip arthritis status post replacement; left hip arthritis, post replacement; lumbar sprain with grade 11-111 spondylolisthesis L4 on L5 and sacroiliac sprain from antalgic gait. Treatment to date has included Lidoderm patches; transcutaneous electrical nerve stimulation unit; physical therapy with unknown functional outcomes, and hip replacement. The MTUS does permit physical therapy in chronic situations. For myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. For neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. Moreover, no duration for the proposed therapy is given, and the status of the independent home program is not addressed. This request for more skilled, monitored therapy is not medically necessary.