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| Case Number: | CM14-0009423 | | |
| Date Assigned: | 02/14/2014 | Date of Injury: | 07/09/2009 |
| Decision Date: | 06/24/2014 | UR Denial Date: | 01/23/2014 |
| Priority: | Standard | Application Received: | 01/24/2014 |

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 67 year old male who reported an injury on 07/09/2009 due to an unknown mechanism. The clinical note dated 11/25/2013 indicated the injured worker reported increased pain in the left hip which was worse with activity. The injured worker reported he felt pain in the anterior groin region and denied numbness and tingling. On physical exam, there was no pain with range of motion. There was tenderness to palpation directly over the greater trochanter. The official x-ray dated 11/25/2013 revealed unchanged position and alignment of left total hip arthroplasty. No periprosthetic fracture or lucency. Mild osteoarthritis of right hip, unchanged. The request for authorization was submitted on 12/13/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 PHYSICAL THERAPY SESSIONS FOR LEFT HIP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

Decision rationale: The request for 18 physical therapy sessions for left hip is non-certified. The California Chronic Pain Medical Treatment Guidelines recommend that 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of evidence of functional improvement from previous physical therapy and it was unclear as to how many sessions the injured worker has completed. It was unclear if the injured worker had significant functional deficits which would need to be addressed with physical therapy. Therefore, per the CA MTUS guidelines, the request for 18 physical therapy sessions for left hip is not medically necessary.