

<b>Case Number:</b>	CM14-0011012		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	04/08/2009
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 and 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 patient is a 39 year-old female who has filed a claim for labral tear and impingement associated with an industrial injury date of April 08, 2009. Review of progress notes reports pain in the groin, left hip swelling, weakness in both hips and left leg upon walking, and numbness and tingling in the right leg. Findings include tenderness and painful range of motion. Treatment to date has included NSAIDs, opioids, Ambien, a total of 24 sessions of physical therapy, 12 sessions of aquatic therapy, steroid injections, and left hip arthroscopy in July 2012, and right hip arthroscopy in October 2013. Utilization review from January 22, 2014 denied the request for bilateral hip arthrogram; physical therapy 2x6 as the patient has had at least 12 post-operative sessions, but there is no documentation regarding the progress and remaining functional deficits; aquatic therapy 2x6 as there is no documentation regarding necessity for reduced-gravity environment; and Voltaren gel 1% 1 large tube and 4 refills as the patient is already on oral NSAID, in addition to other pain medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL HIP ARTHROGRAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis chapter, Arthrography

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. ODG states that hip arthrography is recommended for suspected labral tears. Arthrography gains additional sensitivity when used with CT in the evaluation of internal derangement, loose bodies, and articular cartilage surface lesions. In this case, the patient is recently status post right hip arthroscopy with cam lesion and mild joint space loss seen on fluoroscopy. There is no reason to suspect labral tears at this point. Therefore, the request for bilateral hip arthrogram is not medically necessary.

**PHYSICAL THERAPY TWO (2) TIMES SIX (6): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POSTSURGICAL TREATMENT GUIDELINES,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 98-99.

**Decision rationale:** Page(s) 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment. In this case, the patient has had at least 12 post operative physical therapy sessions. There is no documentation regarding the benefits derived from the sessions, or additional benefits to be gained from additional sessions. Additional information is necessary to support ongoing physical therapy in this patient. Also, the body part to which these sessions are directed to is not indicated. Therefore, the request for physical therapy 2x6 is not medically necessary.

**AQUATIC THERAPY TWO (2) TIMES SIX (6): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, AQUATIC THERAPY, 22

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 22.

**Decision rationale:** According to page 22 of Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. In this case, there is no documentation regarding failure of land-based physical therapy. There is no indication as to why reduced weight-bearing is necessary in this patient. Also, patient has had

previous aquatic therapy, and there is no documentation in describing the benefits derived from these sessions. Therefore, the request for aquatic therapy 2x6 is not medically necessary.

**VOLTAREN GEL 1% TRANSDERMAL EVERY FOUR (4) HOURS, ONE (1) LARGE TUBE, FOUR (4) REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 112.

**Decision rationale:** As stated on page 112 in the Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for relief of osteoarthritis pain in the joints that lend themselves to topical treatment which includes the ankles, elbows, feet, hands, knees, and wrist. This patient has conditions of the right and left hips. Use of Voltaren gel is not indicated for hip conditions. Addition, patient is currently on oral (NSAID) non-steroidal anti-inflammatory drugs, and there is no documentation of intolerance or failure of this medication. Therefore, the request for Voltaren gel 1% one large tube with 4 refills is not medically necessary.