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| <b>Case Number:</b>   | CM14-0068341 |                              |            |
| <b>Date Assigned:</b> | 07/14/2014   | <b>Date of Injury:</b>       | 07/17/2011 |
| <b>Decision Date:</b> | 10/30/2014   | <b>UR Denial Date:</b>       | 05/05/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/13/2014 |

### 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 Texas. 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 57 year old male who sustained a cumulative trauma on 07/17/2011. The patient has been treated conservatively with 12 sessions physical therapy with some improvement. Diagnostic studies reviewed include x-rays of hip and pelvis on 01/27/2014 demonstrated mild degenerative change of the superior aspect of the left hip joint with mild to moderate osteophytes; and right hip prosthesis appears to be in good position without associated bony abnormalities. PT report dated 03/30/2014 states the patient presented with right hip pain which has been improving but continued to have limited functional activities involving walking, on uneven surfaces. The patient has increasing strength along the right lower extremity in hip flexion, extension. Hip internal rotation is 3+/5. The patient has been recommended for additional physical therapy to increase ambulation on all surfaces. Prior utilization review dated 05/05/2014 states the request for Outpatient Additional Physical Therapy (PT) to the Right Hip Two (2) Times Per Week Over Six (6) Weeks is denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy (PT) to the right hip two (2) times per week over six (6) weeks as outpatient:** 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): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip, Physical Therapy

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The claimant had been provided 12 physical therapy sessions. There is an absence in documentation noting that this claimant cannot perform a home exercise program. Based on the records provided, this claimant should already be exceeding well-versed in an exercise program. It is not established that a return to supervised physical therapy is medically necessary and likely to significantly improve or impact the patient's overall pain level and functional status beyond that of her actively utilizing an independent home exercise program. The guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The requested course of physical therapy is excessive and inconsistent with the recommendations of the CA MTUS guidelines. The medical necessity of the request is not established.