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| Case Number: | CM14-0085919 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 08/12/2011 |
| Decision Date: | 09/18/2014 | UR Denial Date: | 05/29/2014 |
| Priority: | Standard | Application Received: | 06/09/2014 |

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 injured worker is a 63-year-old male who reported an injury on 08/12/2011 due to an unknown mechanism. Diagnoses were numbness, muscle pain, chronic pain syndrome, carpal tunnel syndrome, cervical radiculitis, spinal stenosis in cervical region, degenerative disc disease, neck pain, lumbar stenosis, lumbar degenerative disc disease, and low back pain. Past treatments were home exercise program, physical therapy, walking, and H-wave unit. Diagnostic studies were MRI of the lumbar spine and x-ray of the right hip. X-ray of the right hip revealed unremarkable radiographic examination of the right hip. Surgical history was L4-5 fusion and the L3-4 fusion on 07/22/2013. The injured worker reported an 80% improvement in the pain. Physical examination on 06/17/2014 revealed complaints of right hip and right knee pain. The injured worker has been walking a mile each day. He stopped walking due to the pain in right hip. The pain was described as aching and burning in the right hip and aching and stabbing in the right knee. The pain was rated an 8/10 to 10/10 without medications, and a 6/10 to 8/10 with the pain medications. Examination revealed a 5/5 bilateral lower extremity strength. Sensation was intact and equal. Babinski sign was negative. There was tenderness to palpation of the anterior and posterior right hip. There was tenderness over the paraspinals. There was diffuse tenderness to palpation over the right knee. There was a full range of motion in the right knee, and full range of motion in the right hip. Medications were Norco 10/325 mg, Flexeril 7.5 mg, Tenormin 50 mg, Proscar 5 mg, Pravachol 40 mg, and Protonix 40 mg. Treatment plan was for physical therapy, quantity 6. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy QTY; 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine.

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

Decision rationale: The request for physical therapy, quantity 6 is not medically necessary. The California Medical Treatment Utilization Schedule states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling, and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9 to 10 visits for myalgia and myositis and 8 to 10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The injured worker recently had a lumbar fusion where it was reported an 80% improvement in pain. The injured worker walks 1 mile a day. The medical necessity for the request of physical therapy, quantity 6 was not reported. Therefore, the request is not medically necessary.

MRI of right hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, MRI.

Decision rationale: The request for MRI of right hip is not medically necessary. The Official Disability Guidelines recommend MRI as the most accepted form of imaging for finding vascular necrosis of the hip and osteonecrosis. Indications for MRI of the hip osseous, articular or soft tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft tissue injuries and tumors. The injured worker does not meet the recommendations. Therefore, the request is not medically necessary.