

Case Number:	CM15-0004093		
Date Assigned:	01/15/2015	Date of Injury:	01/10/2012
Decision Date:	03/20/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/08/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50-year-old female who reported injury on 01/10/2012. The mechanism of injury was not provided. The diagnosis included localized osteoarthritis not specified primary or secondary pelvic region and thigh. The injured worker was noted to be status post total knee arthroplasty on 10/23/2014. Prior therapies included physical therapy. There was a Request for Authorization submitted for review, dated 12/12/2014. The note of 11/21/2014 revealed the injured worker was participating in physical therapy. The injured worker indicated she wanted to continue with an ice machine for the right hip. The injured worker was noted to be limping. An x-ray was performed of the right hip and right knee. The documentation was difficult to read. The diagnosis included right knee arthrosis. The treatment plan included continuation of physical therapy, an ice machine, and ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue with physical therapy 1-2 times a week for 6 weeks: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for up to 10 visits for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker was undergoing physical therapy. However, there was a lack of documentation of objective functional benefit and the quantity of sessions previously attended. The request as submitted failed to indicate the body part to be treated. Given the above, the request for Continue with physical therapy 1-2 times a week for 6 weeks is not medically necessary.

Ice machine for right hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 & Pelvis Chapter - see Knee & Leg Chapter, Continuous Flow Cryotherapy

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended for up to 7 days postsurgically. The clinical documentation submitted for review failed to provide a rationale for the requested ice machine for the right hip. There was a lack of legible documentation indicating findings on the right hip to support the necessity for the intervention. Additionally, there was lack of documentation indicating the rationale why the injured worker could not utilize ice packs. The request as submitted failed to indicate the frequency for the ice machine and whether the ice machine was for purchase or rental. Given the above, the request for ice machine for right hip is not medically necessary.