

<b>Case Number:</b>	CM15-0103549		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	02/10/2014
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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, Pain Management

### 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 47 year old, male who sustained a work related injury on 2/10/14. The diagnoses have included severe left hip osteoarthritis and status post left total hip replacement. Treatments have included left hip injections, left total hip replacement, physical therapy, occupational therapy and medications. In the PR-2 dated 5/5/15, the injured worker complains of deep tenderness and pain with painful range of motion in left hip. He walks with an antalgic gait. The treatment plan includes a recommendation for a course of physical therapy. Notes indicate that the patient underwent acute rehabilitation following his surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy 2 times a week for 6 weeks, right hip:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis, Physical Medicine Treatment.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it appears the patient underwent acute rehabilitation with physical therapy in addition to postoperative physical therapy on an outpatient basis, and it is unclear how many sessions the patient has already undergone. This makes it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for his diagnoses. In light of the above issues, the currently requested additional physical therapy is not medically necessary.