

Case Number:	CM15-0133244		
Date Assigned:	07/21/2015	Date of Injury:	02/25/2010
Decision Date:	08/21/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/09/2015

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: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 38-year-old male, who sustained an industrial injury on 2/25/2010. The mechanism of injury is unknown. The injured worker was diagnosed as having left hip femoral acetabular impingement and labral tear. Left hip magnetic resonance imaging showed an abnormal femoral head, fluid in the trochanteric bursa and mild bilateral gluteus medius tendinosis. Treatment to date has included therapy and medication management. In a progress note dated 6/9/2015, the injured worker complains of left hip pain. Physical examination showed decreased and painful left hip range of motion and tenderness over the trochanter. The treating physician is requesting surgery and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Physical Therapy, unspecified frequency and duration: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 23.

Decision rationale: The injured worker has evidence of cam type femoroacetabular impingement. The procedure requested is arthroscopic labral repair versus debridement, chondroplasty and left hip femoroplasty. The procedure has been certified. The disputed request pertains to postoperative physical therapy. The request as stated is for unspecified number of visits. Utilization review approved 12 visits and indicated approval of the remaining visits will depend upon evidence of objective functional improvement. California MTUS postsurgical treatment guidelines indicate 18 visits over 12 weeks for osteoarthrosis and Allied disorders. The initial course of therapy is one-half of these 18 visits, which is 9. Then with documentation of continuing functional improvement, an additional course of therapy of the remaining 9 visits may be prescribed. The request as stated does not specify the number of visits. As such, the medical necessity of the request cannot be determined.