MAXIMUS Federal Services

Case Number:	CM15-0136226		
Date Assigned:	07/24/2015	Date of Injury:	01/01/2015
Decision Date:	08/31/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/14/2015

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: Pennsylvania, Ohio, 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 63 year old male, who sustained an industrial injury on 01-01-2015 secondary to a fall resulting in right hip injury. The injured worker was noted to have undergone an open reduction internal fixation-right hip-with intramedullary nail on 01-02-2015. The diagnoses have included right hip intertrochanteric fracture. On provider visit dated 04-28-2015 the injured worker has reported right hip, right knee pain and depression, anxiety and irritability. On examination of the hip revealed decreased and painful range of motion and was noted to use walker to assist with ambulation. Tenderness to palpation of the anterior hip, lateral hip and posterior hip. Patrick's Fabere sign was noted as positive. Right knee was noted as decreased and painful range of motion and tenderness to palpation of the anterior knee, lateral knee, medial knee and posterior knee. McMurrays sign was positive. Diagnoses were note as right hip pain, right hip sprain-strain, status post-surgery-right hip, right knee pain, right knee sprain-strain, anxiety, depression, irritability and nervousness. Treatment to date has included physical therapy, laboratory studies and medication. The provider requested home health care aide, acupuncture (6 visits) to increase range of motion, increase activities and decrease pain and aquatic therapy (12 visits) to increase range of motion, increase activities and decrease pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care aide: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: MTUS recommends home health services only for individuals who are homebound. The records discuss this patient's recent surgery but do not suggest that the patient is homebound. Overall the rationale for the requested home health services is unknown. The request is not medically necessary.

Acupuncture (6 visits): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Page(s): 9-10.

Decision rationale: MTUS Acupuncture Medical Treatment Guidelines recommend continued acupuncture only if functional improvement is objectively documented consistent with MTUS guidelines. The records in this case do not clearly document such functional improvement from past acupuncture. This request is not medically necessary.

Aquatic therapy (12 visits): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chronic Pain Treatment Guidelines Physical Medicine; Aquatic therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: MTUS recommends aquatic therapy as an alternative treatment to land-based therapy. The records in this case do not provide a rationale for aquatic as opposed to land-based therapy, particularly given the patient's extensive past land-based therapy. Guidelines anticipate that by this time the patient would have transitioned to an independent active exercise program. This request is not medically necessary.