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| Case Number: | CM15-0142609 | | |
| Date Assigned: | 08/03/2015 | Date of Injury: | 07/26/1999 |
| Decision Date: | 09/01/2015 | UR Denial Date: | 06/30/2015 |
| Priority: | Standard | Application Received: | 07/22/2015 |

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 76-year-old male, who sustained an industrial injury on 7-26-1999. The mechanism of injury was not noted. The injured worker was diagnosed as having chronic pain syndrome. Treatment to date has included diagnostics, intrathecal pain pump placement, home exercise program, trigger point injections, and medications. On 6-19-2015, the injured worker complains of increased right hip pain and falls. Current medications included, but were not limited to, Norco, Ambien, Cymbalta, Voltaren gel, Fentanyl Citrate solution, and Colace. Exam noted intact deep tendon reflexes, motor strength normal in all extremities except left hip flexion, sensory exam down peripherally, and a wide based gait-forward flexed. He received an injection to his right hip with Xylocaine and Kenalog. The treatment plan included trial for additional physical therapy. No recent physical therapy was documented. On 6-26-2015, he returned due to persisting right hip symptoms. The recommendation was for home exercise program with walking as tolerated, while awaiting physical therapy authorization.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Physical Therapy Sessions 2-3 times a week for 6 weeks for Right Hip Pain: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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 no documentation of specific objective functional improvement with any 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, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.