MAXIMUS Federal Services

Case Number:	CM15-0186016		
Date Assigned:	09/28/2015	Date of Injury:	12/29/2014
Decision Date:	11/10/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/21/2015

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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 56-year-old who has filed a claim for chronic hip pain reportedly associated with an industrial injury of December 29, 2014. In a Utilization Review report dated August 21, 2015, the claims administrator failed to approve a request for 6 sessions of physical therapy for the hip. The claims administrator referenced an August 10, 2015 office visit and a June 29, 2015 RFA form in its determination. The applicant's attorney subsequently appealed. On August 7, 2015, the applicant reported ongoing complaints of hip pain. The applicant had retired from her former employment, it was reported. The applicant had issues with hip impingement syndrome and hip bursitis present. The treating provider stated that he would not recommend hip arthroscopy. The treating provider suggested additional physical therapy and suggested that the applicant consider a hip corticosteroid injection if that, too, prove unsuccessful. On June 29, 2015, the applicant received a hip trochanteric bursa injection and was placed off of work, on total temporary disability, on that date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-injection physical therapy visits 2 times a week for 3 weeks (6) for the right hip:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter (online version).

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Introduction, Physical Medicine.

Decision rationale: No, the request for 6 sessions of post-injection physical therapy for the hip was not medically necessary, medically appropriate, or indicated here. While page 99 of the MTUS Chronic Pain Medical Treatment Guidelines does support a general course of 9-10 sessions of treatment for myalgias or myositis of various body parts, i.e., the diagnoses reportedly present here, this recommendation is, however, qualified by commentary made on page 8 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that demonstration of functional improvement is necessary at various milestones in the treatment program in order to justify continued treatment and by commentary made in the MTUS Guideline in ACOEM Chapter 3, page 48 to the effect that it is incumbent upon a treating provider to furnish a prescription for physical therapy which clearly states treatment goals. Here, however, the applicant was placed off of work, on total temporary disability, on June 29, 2015, suggesting a lack of functional improvement as defined in MTUS 9792.20e, despite receipt of earlier unspecified amounts of physical therapy over the course of the claim. The attending provider failed to outline how (or if) the applicant could stand to gain from further treatment, going forward. Clear treatment goals were not seemingly articulated. Therefore, the request was not medically necessary.