MAXIMUS Federal Services

Case Number:	CM15-0199832		
Date Assigned:	10/15/2015	Date of Injury:	09/26/2012
Decision Date:	11/30/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	10/12/2015

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: Emergency 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 injured worker is a 42 year old male who sustained an industrial injury September 26, 2012. Past history included lap band surgery and knee surgery (unspecified). Diagnoses are; residuals of musculoligamentous lumbosacral strain; residuals of traumatic contusion, right hip; degenerative arthritis, right hip. An orthopedic evaluation dated April 16, 2015, revealed the injured worker is [redacted] and [redacted] pounds. The physician documented an MRI of the right hip shows extensive degenerative changes consistent with probable osteoarthritis. According to a pain management re-evaluation dated May 19, 2015, the injured worker presented for follow-up reporting he has started the [redacted] approximately three weeks ago, he had a good response to his last block, he rated his low back pain 3-4 out of 10 and he is performing home stretching exercises. Physical exam is documented as unchanged from prior evaluation. According to a primary treating physician's progress report dated August 5, 2015, the injured worker presented for follow-up evaluation reporting he is receiving physical therapy and his pain is decreased in his low back. The physician documented an x-ray of the right hip showed arthritis. He reported returning to work on June 11, 2015 and performing clerical work five hours per day. He can only walk short distances and utilizes a cane walker. Physical examination is documented as unchanged from prior evaluations. At issue, is a request for authorization dated August 5, 2015, for a motorized scooter and physical therapy 2 x 6, right hip and thigh. According to utilization review dated September 3, 2015, the requests for Physical Therapy 2 x 6 right hip and thigh and Motorized Scooter were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT 2x6 Right Hip and Thigh: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: As per MTUS Chronic pain guidelines, physical therapy may be recommended for painful conditions with an initial trial of 6 and limited to no more than 10 with patient's condition. Patient has undergone an unknown number of PT sessions with no documentation of any objective improvement in functional status or pain. This request alone exceeds maximum recommended number of PT sessions. With no benefit and excessive number of PT sessions, this request is not medically necessary.

Motorized Scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: As per MTUS chronic pain guidelines, power mobility devices such as scooters are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Not a single criterion is met. Therefore, the request is not medically necessary.