

Case Number:	CM15-0214394		
Date Assigned:	11/04/2015	Date of Injury:	09/09/2013
Decision Date:	12/15/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/30/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 43 year old male who sustained an industrial injury September 9, 2013. Diagnoses are sprain shoulder arm right, not otherwise specified; adhesive capsulitis shoulder, right; muscle-ligament disorder, right; inguinal sprain. According to a doctor's first report of occupational injury dated September 18, 2015, the injured worker presented with complaints of right shoulder pain with radiation to the arm up to the last three digits and right groin pain. He rated his pain 6 out of 10. Past treatments included physical therapy, medication, and subacromial cortisone injection right shoulder. Current medication included Gabapentin, Naproxen, and Tramadol which decreases his pain level by 50%. Physical examination revealed; mild antalgic gait favoring the right leg; right upper extremity- limited range of motion of the right shoulder due to pain in all planes with tenderness; right lower extremity- decreased rotation and extension due to tightness of the right hip, flexor muscles with moderate tenderness of the hip flexor tendons and inguinal area; sensation is equal throughout. Treatment plan included continued medication, urine drug screen, cortisone injection right shoulder pending, and at issue, a request for authorization for physical therapy right inguinal area-hip. A report of an electrodiagnostic study dated April 29, 2015, is present in the medical record and documented as an abnormal study. According to utilization review dated October 7, 2015, the request for physical therapy 2 times a week x 6 weeks (12), right inguinal area-hip is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks for the right inguinal area/hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip/Pelvis, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week from six weeks to the right inguinal area and hip is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are sprained shoulder/arm NOS; adhesive capsulitis right shoulder; and musculoligamentous DIS NOS - right flexor muscles/inguinal sprain. Date of injury is September 9, 2013. Request for authorization is October 1, 2015. According to a September 18, 2015 progress note, subjective complaints include ongoing right shoulder pain. Objectively, there was an antalgic gait. There was tightness at the right hip with tenderness with tenderness in the inguinal area. The documentation does not contain physical therapy progress notes dating back to the time of the injury. It is unclear whether physical therapy was geared toward the right shoulder or the right hip. The total number of physical therapy sessions is not specified. There is no documentation demonstrating objective functional improvement from prior hip physical therapy. There are no compelling clinical facts indicating additional physical therapy (over the recommended guidelines) is clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation including the total number of physical therapy sessions and documentation indicating objective functional improvement, physical therapy two times per week for six weeks to the right inguinal area and hip is not medically necessary.