

Case Number:	CM15-0086871		
Date Assigned:	05/11/2015	Date of Injury:	01/08/2010
Decision Date:	06/12/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	05/06/2015

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: 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 injured worker is a 56-year-old male, who sustained an industrial injury on January 8, 2010. He reported injuries of the right hip, right wrist, and right hand. The injured worker was diagnosed as having right hip osteoarthritis and right carpal tunnel syndrome. On November 11, 2014, he underwent a right wrist arthroscopy. Diagnostic studies to date have included x-rays and MRI. It was noted by the treating physician that x-rays of the right hip and femur revealed severe arthritis, and right wrist x-rays revealed no degenerative changes. Treatment to date has included work modifications, a single point cane, wrist bracing, wrist injections, physical therapy for the right hip and right wrist, postoperative physical therapy for the right wrist, and medications including topical pain, muscle relaxant, proton pump inhibitor and non-steroidal anti-inflammatory. On March 11, 2015, the injured worker complains of marked right hip pain with grinding and catching. The physical exam revealed a right coxalgic gait, internal and external rotation range of motion was decreased 20 degrees, and full flexion, extension, abduction, and adduction. There was marked capsular tenderness. The treatment plan includes a request for physical therapy for the right hip. The injured worker's work status was temporarily totally disabled. The requested treatments are 12 sessions of physical therapy for the right hip and right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3x4 (12) for the right hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic).

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The injured worker has completed a course of physical therapy in the past for his hip. Additional physical therapy sessions may be necessary in this case, but the amount requested exceeds the recommendations of the MTUS Guidelines. The request for Physical therapy 3x4 (12) for the right hip is determined to not be medically necessary.

Physical therapy 3x4 (12) for the right hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic).

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The injured worker has completed a course of post-surgical physical therapy for his wrist and is no longer in the post-surgical period. The amount of therapy requested is in excess of the recommendations of the Chronic Pain Medical Treatment Guidelines. The request for Physical therapy 3x4 (12) for the right hand is determined to not be medically necessary.