

Case Number:	CM14-0092700		
Date Assigned:	07/25/2014	Date of Injury:	02/28/2013
Decision Date:	09/15/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/19/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 58-year-old female who reported an injury on 02/28/2013. The mechanism of injury was from repetitive motion. The diagnoses included inguinal sprain/strain, sprain of the hip, bursitis-trochanteric. Previous treatments included physical therapy, medication. The diagnostic testing included magnetic resonance imaging (MRI) x-rays. Within the clinical note dated 07/17/2013, it was reported the injured worker complains of left hip pain. She described the pain as a dull pain. She reported her pain as moderate to severe and intermittent to constant. Upon the physical examination, the provider noted the injured worker had tenderness of the left hip, greater trochanter, lesser trochanter and groin. The left hip range of motion was flexion on the left at 80 to 100 degrees, and extension on the left of 10 to 19 degrees. The provider noted the injured worker had no muscle weakness. The request submitted is for physical therapy 2 times a week for 6 weeks of the left hip, and left foot. However, the rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x week x 6 weeks left hip, left foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion. The guidelines allow for fading of treatment frequency plus active self directed home physical medicine. The guidelines note for neuralgia and myalgia 8 to 10 visits of physical therapy are recommended. There is lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. There is lack of documentation indicating the injured worker had objective functional gains from the previous therapy. There is lack of documentation demonstrating the injured worker had decreased functional ability, or decreased strength in flexibility. The number of sessions the provider is requesting exceeds the guidelines recommendations. Therefore, the request is not medically necessary and appropriate.