

Case Number:	CM15-0091402		
Date Assigned:	05/15/2015	Date of Injury:	12/30/2013
Decision Date:	06/22/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/12/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 40-year-old male, who sustained an industrial injury on 12/30/2013. He reported having a lump on the left side of his pelvic area. He was diagnosed with left suprapubic mass consistent with hernia. A computed tomography scan revealed bilateral inguinal hernias. Treatment to date has included surgery, medications and physical therapy. According to a physical therapy progress report dated 02/20/2015, the injured worker was status post 3 month right inguinal hernia repair and 2-month status post left inguinal repair with residual discomfort in the region of the repairs but was gradually progressing with hip/lower quarter range of motion, strength and function. He still had marked weakness in his lower quarter muscles, especially in the proximal hip musculature. His physical therapy diagnosis was tissue impairment bilateral hip/groin stage II-III. He had completed 8 out of the 12 authorized physical therapy visits. The provider recommended that the injured worker continue physical therapy 2 times a week for 4-6 weeks after his authorization ended to progress his strength, endurance and function. His prognosis was good. According to a permanent and stationary report dated 02/23/2015, the injured worker still had symptoms on both sides. He could not carry anything heavy. Physical examination demonstrated well-healed groins and normal testicles. Diagnoses of residual problems included residual subjective discomfort over both groins radiating to scrotum while doing certain activities with a degree of loss of pre-injury capacity, loss of pre-injury capacity, needs preventative measures, status post right inguinal hernia repair and status post left inguinal hernia repair. The provider noted that if both groins are aggravated the injured worker

might need further therapy in the form of medications and injections. Currently under review is the request for physical therapy for left inguinal hernia repair twice a week for three weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for left inguinal hernia repair, twice a week for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request cannot be medically necessary.