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| Case Number: | CM14-0209407 | | |
| Date Assigned: | 03/02/2015 | Date of Injury: | 12/03/2006 |
| Decision Date: | 04/10/2015 | UR Denial Date: | 12/04/2014 |
| Priority: | Standard | Application Received: | 12/15/2014 |

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. 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: Physical Medicine & Rehabilitation, Pain Management

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 (IW) is a male who sustained an industrial injury on 12/03/2006. He has reported upper back pain that has increased and is rated as 6/10 with constant neck stiffness. The IW also complains of left low back pain with radiculitis. He has constant neck stiffness and a frequent left sided headache as well as an increasing left side low back pain described as deep, stabbing, and extending into the lower extremities more on the left. Diagnoses include thoracic compression; fractures, lumbar disc disease/Spondylolisthesis; intractable pain; and left and right knee arthropathy; post-operative arthroscopies. Treatment to date includes opioid pain relievers. A progress note from the treating provider dated 11/04/2014 indicates increased thoracic kyphosis and tenderness to palpation at thoracic 2-3. The treatment plan includes continuing Oxycontin and Percocet prescriptions and requesting for physical therapy. On 12/04/2014 Utilization Review non-certified a request for Physical Therapy QTY 8The MTUS, ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the patient is already participating in independent home exercise program. There is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. In the absence of such documentation, the current request for physical therapy is not medically necessary.