

Case Number:	CM15-0005651		
Date Assigned:	01/26/2015	Date of Injury:	04/08/2013
Decision Date:	03/12/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/12/2015

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: California

Certification(s)/Specialty: Emergency 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 53 year old male, who sustained an industrial injury on 4/8/13. He has reported low back pain. The diagnoses have included thoracic lumbar spine bilateral sciatica, lumbar radiculopathy, insomnia secondary to pain and lumbar degenerative disc disease with disc herniation. Treatment to date has included physical therapy, TENS unit, home exercise program and medications. (MRI) magnetic resonance imaging of thoracic spine performed on 7/9/14 revealed desiccated T2-3, 3-4, 4-5, 5-6, 6-7 and 7-8 thoracic spondylosis with no impingement on the spinal cord and (MRI) magnetic resonance imaging of 5/7/13 to the lumbar spine revealed 6mm disc protrusion and annular tear at L5-S1. Currently, the IW complains of back pain with radiation to foot/ankle, states he has good and bad days. Physical exam of 11/6/14 revealed limited range of motion of lumbar/thoracic spine; otherwise no abnormality noted. It is noted on the exam of 10/9/14, the IW stated he had increased pain due to therapy not being approved. On 12/9/14 Utilization Review non-certified physical therapy 3 times a week for 6 weeks, noting lack of documented objective clinical improvement from previous 54 sessions of physical therapy. The MTUS, ACOEM Guidelines, (or ODG) was cited. On 1/7/15, the injured worker submitted an application for IMR for review of physical therapy thoracic/lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Thoracic/Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Lumbar Spine Section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Low Back Complaints, Page 300. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy

Decision rationale: The requested Physical Therapy Thoracic/Lumbar, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and ODG Treatment in Workers Compensation, ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit. The injured worker has back pain with radiation to foot/ankle, states he has good and bad days. The treating physician has documented limited range of motion of lumbar/thoracic spine; otherwise no abnormality noted. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions. The criteria noted above not having been met, Physical Therapy Thoracic/Lumbar is not medically necessary.