

Case Number:	CM15-0208588		
Date Assigned:	10/27/2015	Date of Injury:	08/12/2015
Decision Date:	12/08/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/22/2015

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: Physical Medicine & Rehabilitation

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 61 year old male, who sustained an industrial injury on 8-12-2015. Medical records indicate the worker is undergoing treatment for left thoracic vertebral fracture. A recent progress report dated 9-2-2015, reported the injured worker complained of ongoing mid-back pain and intermittent back spasm rated 7 out of 10. Physical examination revealed lower thoracic and lumbar paraspinal tenderness to palpation. Treatment to date has included 6 visits of physical therapy and medication management. The physician is requesting Physical therapy 2 times a week for 3 weeks for the thoracic spine. On 10-9-2015, the Utilization Review noncertified the request for Physical therapy 2 times a week for 3 weeks for the thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks for the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Chapter: Neck and Upper Back (Acute & Chronic) - Physical therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. Submitted reports have no new injury or specific neurological deficit progression to support for further physical therapy. The Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT/OT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further quantity of 6 additional PT sessions without extenuating circumstances beyond guidelines criteria. The Physical therapy 2 times a week for 3 weeks for the thoracic spine is not medically necessary and appropriate.