

Case Number:	CM13-0029347		
Date Assigned:	11/01/2013	Date of Injury:	11/24/1999
Decision Date:	02/11/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine 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 physician 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 patient is a 52-year-old male with dates of injuries 11/24/1999; CT 01/01/1991 to 07/11/2007. He has a long and complicated medical history due to the length of time he has been treating. He is currently being followed by [REDACTED]. [REDACTED] last saw the patient on 08/20/2013 and requested the treatments which are the subject of this review. On 08/20/2013, [REDACTED] assigned the patient the following diagnoses: 1. Status post left shoulder arthroscopic surgery with subacromial decompression, 2. Myoligamentous sprain/strain, cervical spine and lumbar spine, 3. De Quervain's tendinitis, bilateral wrists, 4. Left carpal tunnel syndrome, 5. Left lower extremity radiculitis, 6. Lumbar spine herniated nucleus pulposus, L2-3, L3-4 and L4-5, 7. Left shoulder impingement syndrome with Type II acromion, 8. Acromioclavicular joint hypertrophy, 9. Small capsular tear with tendinosis, 10. Right wrist sprain/strain, 11. Cervical spine myofascial pain syndrome. Subjective complaints on 08/20/2013 were as follows: "The patient complains of constant headaches. He also complains of constant neck pain, rated 8/10, with radiation to the left upper extremity. He notes that the left side of his head feels numb with pins and needles sensation. He has constant low back pain, rated 0.5/10, with associated numbness, left worse than the right as well as stiffness. He reports intermittent left shoulder pain. He further complains of constant bilateral wrist/hand pain, rated 5.5/10." Physical exam is as follows: "The patient weighs 246 pounds. Blood pressure reading is 123/72. Right hand grip strength is 32/34/30 kg/force. Left hand grip strength is 18/20/20 kg/force. On cervical spine examination, there are grade 2+ trigger points. Lumbar spine range of motion reveals flexion at 30/60, extension 10/25, right lateral bend 15/25, and left lateral bend 15/25, Straight leg raise and Kemp's testing are positive bilaterally. Lower extremity motor strength weakness is noted in

IMR ISSUES, DECISIONS AND RATIONALES

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

1 office chair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 78.

Decision rationale: "The employer's (or insurer's) willingness and ability to eliminate obstacles, and arrange an appropriate on-the-job recovery, based on the provider's work prescription, will determine the date when the employee actually gets back to work. Additionally, employers consistently monitor and evaluate the progress of return-to-work programs in order to identify opportunities for improvement." The employer is under no obligation to provide equipment that is not medically necessary simply to increase the employee's comfort. If, however, the employee has permanent impairment which qualifies as a disability under the Americans with Disabilities Act of 1990, the ADA requires employers to provide necessary reasonable accommodations for qualified individuals with disabilities. This typically requires the employee to provide documentation from the treating physician that: (1) describes the nature, severity, and duration of the employee's impairment, the activity or activities that the impairment limits, and the extent to which the impairment limits the employee's ability to perform the activity or activities; and (2) substantiates why the accommodation is needed, in this case an ergonomic chair. Documentation present in the medical record currently does not substantiate the provision of an ergonomic chair.

Physical therapy 2 times per week for 4 weeks to the lumbar spine with traction and deep tissue massage: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines 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, 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. The request is not medically necessary.

