

<b>Case Number:</b>	CM14-0079745		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/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 57-year-old female who has submitted a claim for lumbar intervertebral lumbar disc disorder with myelopathy, lumbar sprain and strain, sprain and strain of the sacroiliac region, and unspecified arthropathy of the shoulder region; associated with an industrial injury date of 05/05/2011. Medical records from 2013 to 2014 were reviewed and showed that patient complained of low back and right shoulder pain with radicular symptoms, intermittent abdominal pain and difficulty falling and staying asleep. Physical examination showed tenderness of the right rotator cuff, acromioclavicular joint and deltoid muscle, and paravertebral muscles in the lower lumbar region. Range of motion of the right shoulder and lumbar spine was limited. Impingement, Jobe's, Hawkins', and cross chest adduction tests were positive on the right shoulder. Straight leg and Bragard tests were positive on the right leg. Treatment to date has included medications, acupuncture, physical therapy, home exercise program and epidural injections. Utilization review, dated 04/21/2014, denied the request for physical therapy because there was no documentation of the patient's prior physical therapy and inability to continue independently with the previously prescribed home exercise program; denied the request for treatment with [REDACTED] because there was no documentation of the patient's initial internal medicine evaluation and comprehensive treatment plan, and ongoing internal medicine treatment was not supported; and denied the request for consultation with a sleep studies specialist there was no documentation regarding the results of a concurrently requested psychological evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (PT) X 12 treatments lumbar, right shoulder, cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

**Decision rationale:** As stated on page 98 to 99 of CA MTUS Chronic Pain Medical Treatment Guidelines, physical therapy is beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient complains of right shoulder and low back pain with radicular symptoms despite medications, physical therapy, acupuncture, and epidural injections. The patient is currently on a home exercise program. However, the medical records submitted for review did not include records from her previous physical therapy sessions, and the total number of sessions and response to therapy was not included. Moreover, there is no discussion regarding the need for supervised physical therapy sessions, since the patient should be well-versed in a home exercise program, having had physical therapy in the past. Therefore, the request for Physical Therapy (PT) X 12 treatments Lumbar, Right Shoulder, Cervical Spine is not medically necessary.

**Treatment with [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Worker's Compensation (ODG-TWC) Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Edition, (2004) Chapter 7 - Independent Medical Examinations and Consultation pages 127 and 156

**Decision rationale:** On pages 127 and 156 of the CA MTUS ACOEM Independent Medical Examinations and Consultations state that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. Guidelines also state that a referral request should specify the concerns to be addressed in the independent of expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. In this case, the patient complains of intermittent abdominal pain and gastrointestinal complaints. However, the medical records submitted for review did not include physical examination results of the abdomen. Moreover, there is no discussion regarding uncertainty of diagnosis or complexity of issues of abdominal pain to

warrant an internal medicine referral. Therefore, the request for treatment with [REDACTED] is not medically necessary.

**Consultation with sleep studies specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers Compensation (ODG-TWC) Pain Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 - Independent Medical Examinations and Consultation pages 127 and 156

**Decision rationale:** On pages 127 and 156 of the CA MTUS ACOEM Independent Medical Examinations and Consultations state that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. Guidelines also state that a referral request should specify the concerns to be addressed in the independent of expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. In this case, the patient complains of difficulty of sleeping, obtaining only 2-3 hours of sleep per day. Psychological evaluation was approved on 04/21/2014. However, the medical records submitted for review did not show evidence of failure of first line sleep interventions such as psychological treatment and medical management to warrant a sleep specialist consultation. Moreover, the medical records did not reveal uncertainty or complexity of issues on sleep management. Therefore, the request for Consultation with Sleep Studies Specialist is not medically necessary.