

<b>Case Number:</b>	CM15-0139237		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	01/31/1995
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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, Massachusetts

Certification(s)/Specialty: Preventive Medicine, Occupational 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 54-year-old female who sustained an industrial truck accident injury on 01/31/1995 with multiple trauma, facial fractures, traumatic amputation of the right upper extremity and pelvic fracture requiring extensive surgical interventions. The injured worker was diagnosed with traumatic brain injury with cognitive impairment, significant C5-6 and C6-7 with left upper extremity radiculopathy, myofascial pain, chronic low back and hip pain, depression, headaches and post-traumatic stress disorder. The injured worker is status post multiple maxillofacial reconstructions, dental surgeries and right below the elbow amputation with revisions. Treatment to date has included diagnostic testing, multiple invasive surgeries, transcutaneous electrical nerve stimulation (TEN's) unit, physical therapy, home exercise program, splint therapy, right prosthetic device, rehab psychology, psychiatric and psychological therapy, biofeedback therapy, cognitive behavioral therapy (CBT) and medications. According to the primary treating physician's progress report on June 5, 2015, the injured worker continues to experience spasm and pain of the lumbar, thoracic, and sacral area rated at 3/10 on the pain scale with medications. Temporomandibular Joint (TMJ) and facial pain averages 5/10. The injured worker continues to actively participate in psychological pain management. The injured worker ambulates with a normal gait without assistive devices with decreased range of motion of the lumbar spine due to pain. Left arm tires from repetitive and overuse. Current medications are listed as Flector patch, Ibuprofen and Paroxetine. Treatment plan consists of continuing psychotherapy treatment, staying active and the current request for physical therapy (8 sessions) for the lumbar and cervical spine, right hip and left upper extremity, pool therapy maintenance for the lumbar and cervical spine, right hip and left upper extremity and a queen size Tempur-Pedic bed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Pool therapy maintenance: lumbar & cervical spine, left upper extremity, right hip:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, Physical medicine Page(s): 22, 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**Decision rationale:** While aquatic therapy may be a recommended alternative from land based physical therapy, supporting rational for aquatic versus and therapy, as well as details of the pool therapy including number of requested sessions and whether or not the therapy will be supervised and part of a larger rehabilitation program, were not included in the provided documentation. Therefore, the requested pool therapy is not medically necessary.

**Physical therapy, 8 sessions for lumbar and cervical spine, left upper extremity, right hip:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-101.

**Decision rationale:** According to MTUS guidelines physical therapy is recommended as it is helpful in "controlling symptoms such as pain, inflammation and swelling to improve the rate of healing of soft tissue injuries." The MTUS guidelines allow for an initial course of up to 9-10 PT visits over 8 weeks. From the reviewed medical records it appears that the IW has already had at least 8 sessions of initial PT. There is no documentation of efficacy with therapy or supporting rational if the IW is not able to perform an independent home exercise program (HEP). Consequently based on the guidelines and my review of the provided records I believe the requested sessions of physical therapy are not medically necessary at this time.

**Tempur Pedic queen size bed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 11th edition, 2014, low back/ Mattress selection.

**Decision rationale:** According to ODG guidelines, "there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain." Given the lack of supporting guidelines or clinical efficacy related to specific bedding choice, the requested intervention is not medically necessary.