

Case Number:	CM15-0141080		
Date Assigned:	07/30/2015	Date of Injury:	06/02/2007
Decision Date:	08/28/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	07/20/2015

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 49 year old female, who sustained an industrial injury on 6-02-2007. Diagnoses include left shoulder adhesive capsulitis, left shoulder decompression surgery, depression associated with chronic pain, thoracic radiculopathy, low back pain, lumbar facet pain, and sacroiliitis. Treatment to date has included surgical intervention as well as conservative treatment consisting of an implanted dorsal column stimulator T11-T12, medications including Seroquel, Neurontin, Pristiq, Trazodone, Inderal and Tylenol #4, cognitive behavioral therapy, and the use of a CPAP machine for sleep apnea. She underwent revision of the dorsal column stimulator pocket on 12/15/2014. Per the Primary Treating Physician's Progress Report dated 4-21-2015, the injured worker reported persistent neck and thoracic region pain radiating to the left upper extremity. Pain was rated as 7 out of 10. Physical examination revealed spasms in the cervical and thoracic paraspinal muscles. Dysesthesia was noted to light touch in the thoracic paraspinals, worse on the left. There was also dysesthesia noted to light touch in the left upper extremity. The plan of care included medication management and referral for use of a Continuous Positive Airway Pressure (CPAP) machine. Authorization was requested for a sleep CPAP machine including one full time mask, filter kit ultrafine, RP CPAP ultrafine filter and REM star prolpypus pollen filer pack.

IMR ISSUES, DECISIONS AND RATIONALES

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

Filter Kit Ultrafine Lot #130129: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Blue Cross Clinical UM Guideline.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Sleep Studies.

Decision rationale: The requested Filter Kit Ultrafine Lot #130129, is medically necessary. CAMTUS is silent. Official Disability Guidelines, Pain, Sleep Studies note such studies and subsequent treatment is appropriate for diagnosed obstructive sleep apnea. The injured worker has persistent neck and thoracic region pain radiating to the left upper extremity. Pain was rated as 7 out of 10. Physical examination revealed spasms in the cervical and thoracic paraspinal muscles. Dysesthesia was noted to light touch in the thoracic paraspinals, worse on the left. There was also dysesthesia noted to light touch in the left upper extremity. The treating physician had documented the presence of sleep apnea and the medical necessity for a CPAP machine. The criteria noted above having been met, Filter Kit Ultrafine Lot #130129 is medically necessary.

REM Star Prolpyus Pollen Filter Pack of #130604: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Blue Cross Clinical UM Guideline.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Sleep Studies.

Decision rationale: The requested REM Star Prolpyus Pollen Filter Pack of #130604 is medically necessary. CAMTUS is silent. Official Disability Guidelines, Pain, Sleep Studies note such studies and subsequent treatment is appropriate for diagnosed obstructive sleep apnea. The injured worker has persistent neck and thoracic region pain radiating to the left upper extremity. Pain was rated as 7 out of 10. Physical examination revealed spasms in the cervical and thoracic paraspinal muscles. Dysesthesia was noted to light touch in the thoracic paraspinals, worse on the left. There was also dysesthesia noted to light touch in the left upper extremity. The treating physician had documented the presence of sleep apnea and the medical necessity for a CPAP machine. The criteria noted above having been met, REM Star Prolpyus Pollen Filter Pack of #130604 is medically necessary.