MAXIMUS Federal Services

Case Number:	CM15-0165681		
Date Assigned:	09/03/2015	Date of Injury:	07/13/2007
Decision Date:	10/08/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/24/2015

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 47-year-old female who sustained an industrial injury on July 13, 2007 resulting in headaches and neck and upper back pain. Diagnoses have included status post cervical fusion, cervical radiculopathy, and thoracic outlet syndrome. Documented treatment includes medication including Morphine, Percodan, Flexeril, and unspecified over-the-counter medications. The injured worker continues to present with muscle spasms in her neck and upper back, and constant neck pain which radiates to her head and down her upper extremities. This is aggravated by prolonged sitting and lying down, as well as movement. Additionally, she has reported radiating numbness and tingling from her mid back down her lower extremities, and problems losing her balance. The treating physician's plan of care includes a cervical occupational therapy consultation and motorized wheel chair. Current work status is not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy consultation (Cervical): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Physical Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM chapter 7, page 127.

Decision rationale: Based on the 8/4/15 progress report provided by the treating physician, this patient presents with neck pain that is unchanged and constant. The treater has asked for OCCUPATIONAL THERAPY CONSULTATION (CERVICAL) but the requesting progress report is not included in the provided documentation. The patient's diagnosis per request for authorization dated 8/10/15 is cervicalgia. The RFA dated 8/10/15 also states "She has severe cervical pain which interferes with ability to ambulate." The patient has had weight loss of unspecified amount, and decreased activity due to cervical pain per 8/4/15 report. The patient also suffers from depression and insomnia per 8/4/15 report. The patient had a ruptured appendix 2 months ago, and had surgery last month with ongoing bowel symptoms per 5/7/15 report. The patient is currently taking Percocet per 5/7/15 report. The patient is unable to work and disabled per QME dated 3/16/15. ACOEM chapter 7, page 127 states: "The occupational 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. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient." In this case, it is not known if the patient had physical therapy in the past. Per utilization review letter dated 8/13/15, patient is currently undergoing water therapy but denies request due to lack of clear rationale. The ACOEM Guidelines support the referral of patients 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. The patient is currently disabled, and not able to work. The treater is requesting this consultation to occupational therapy as the patient has difficulty ambulating due to chronic cervical pain, which is reasonable and in accordance with the guidelines. Therefore, it IS medically necessary.

Motorized wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: Based on the 8/4/15 progress report provided by the treating physician, this patient presents with neck pain that is unchanged and constant. The treater has asked for motorized wheelchair the requesting progress report is not included in the provided documentation. The patient's diagnosis per request for authorization dated 8/10/15 is cervicalgia. The RFA of 8/10/15 also states: "I wanted her evaluated for a motorized wheelchair

as she will not be able to proper herself." The patient has had weight loss of unspecified amount, and decreased activity due to cervical pain per 8/4/15 report. The patient also suffers from depression and insomnia per 8/4/15 report. The patient had a ruptured appendix 2 months ago, and had surgery last month with ongoing bowel symptoms per 5/7/15 report. The patient is currently taking Percocet per 5/7/15 report. The patient is unable to work and disabled per QME dated 3/16/15. MTUS Power mobility devices (PMDs) section pg. 99: Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Per QME dated 3/16/15, patient had antalgia of left lower extremity and was using a cane in right upper extremity. The patient is s/p cervical discectomy and fusion at C3-6 with slight improvement per QME dated 3/16/15. The patient has a forward posture of cervical spine and wide-based gait that is unsteady per QME of 3/16/15. MTUS does not support the issuance of motorized scooter/wheelchair if the functional mobility deficit can be resolved by a prescription cane, which this patient was using on 3/16/15 report. The treater does not provide evidence of any subsequent re-injury that would necessitate a motorized wheelchair. Therefore, the request IS NOT medically necessary.