

Case Number:	CM15-0204051		
Date Assigned:	11/19/2015	Date of Injury:	05/08/2013
Decision Date:	12/30/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/16/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 66-year-old female who reported an industrial injury on 5-8-2013. Her diagnoses, and or impressions, were noted to include: cervicgia; and depression. A medical services liability dispute was noted on 10-9-2015, noting that the left shoulder was not an accepted body part. No imaging studies were noted. Her treatments were noted to: medication management with toxicology studies (9-2-15); and modified work duties. The progress notes of 9-2-2015 reported: increased neck, lower back and head pain, rated 4 out of 10, that radiated to the neck, left shoulder-arm, and upper back, aggravated by prolonged activity, and helped by medication which reduced her pain down from a 7 out of 10, x 6-7 hours; and interrupted sleep due to pain with the use of 5 pillows to sleep; a profound loss of pleasure and was easily upset and irritated. The objective findings were noted to include: moderate obesity; that she appeared calm & depressed; a slowed and stooped gait; restricted cervical range-of-motion, with tenderness to the cervical spinous processes; restricted lumbar range-of-motion from pain, with tenderness over the left lumbar para-vertebral muscles, mid-upper back spinous process muscles; positive bilateral lumbar facet loading and left straight leg raise; restricted right shoulder range-of-motion, with tenderness in the joint; pain in the left shoulder with limited range-of-motion, joint tenderness, and positive shoulder crossover test and empty cans test; restricted motor examination due to pain; and persistent pain symptoms relieved by her current medications. The physician's requests for treatment were noted to include that she requested to continue physical therapy because her sessions provided a 20% improvement, so additional 6 physical therapy sessions for her head, left neck, shoulder and upper back region; and a recliner

bed for sleep due to the need for 5 pillows. The Request for Authorization, dated 9-11-2015, was noted to include: additional physical therapy for the head, neck and shoulder, and a recliner bed. The Utilization Review of 9-22-2015 non-certified the request for continued physical therapy, 1 x a week x 6 weeks, for the head, neck and left shoulder, and for a recliner bed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued physical therapy x6, once weekly for 6 weeks (head and neck): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Neck & Upper Back Procedure Summary (Online Version): Physical therapy guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed physical therapy. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. In the provided clinical documentation. Therefore, the request is not medically necessary.

Recliner bed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Policy Bulletins Number 0543 Subject: Hospital Beds and Accessories Policy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The equipment itself is not rentable or able to be used by successive patients. It does not serve a primary medical purpose that cannot be accomplished without it. The ODG does not recommend specific beds or mattresses in the treatment of chronic pain. Therefore, criteria have not been met per the ODG and the request is not medically necessary.