

<b>Case Number:</b>	CM15-0205459		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	07/21/2009
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	10/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: New York, West Virginia, Pennsylvania  
 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 56 year old male, who sustained an industrial injury on 07-21-2009. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for brachial neuritis or radiculitis, shoulder impingement syndrome, lumbar radiculopathy, stomach function disorder, and anxiety. Medical records (01-28-2015 to 10-07-2015) indicate ongoing neck pain, bilateral shoulder pain, headaches, and low back pain with radiation into the lower extremities. Pain levels were rated 7 out of 10 in severity on a visual analog scale (VAS). Records also indicate no significant improvement in pain levels, activity levels or level of functioning. Per the treating physician's progress report (PR), the IW had been working with restrictions for several months. The physical exam, dated 10-07-2015, revealed tenderness over the cervical paravertebral musculature, restricted range of motion (ROM) in the cervical spine, decreased sensation in the bilateral hands, tenderness to palpation of the bilateral shoulders, restricted ROM in both shoulders, positive impingement sign bilaterally, tenderness and spasms in the lumbar muscles, restricted ROM in the lumbar spine, and positive straight leg raises bilaterally. Relevant treatments have included: 12 sessions of aquatic therapy with some benefit, acupuncture, lumbar trigger point injections, psychotherapy, work restrictions, and pain medications. Multiple requests for authorization (07-27-2015, 08-12-2015 & 10-07-2015) shows that the following services were requested: 12 sessions of aquatic therapy for the bilateral shoulders, neck and low back, a sleep study, and one (1) functional capacity evaluation. The original utilization review (10-15-2015) non-certified the request for 12 sessions of aquatic

therapy for the bilateral shoulders, neck and low back, a sleep study, and one (1) functional capacity evaluation.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Aqua therapy, bilateral shoulders/ lower back/ neck, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, Aquatic therapy.

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

**Decision rationale:** Guidelines state that aquatic therapy is specifically recommended where reduced weight bearing is desirable. Guidelines state that during physical therapy, fading of treatment frequency plus active self directed home physical medicine should occur. In this case, there is no documentation of failed land-based physical therapy and no documentation of the patient's inability to tolerate a gravity-resisted therapy program. The request for aquatic therapy is not medically necessary and appropriate.

**Sleep study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain - Polysomnography (sleep study).

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

**Decision rationale:** Guidelines only recommend sleep studies and subsequent sleep appliances with satisfaction of multiple criteria. A review of the medical records did not indicate that the request is medically necessary nor in accordance with ODG which recommends cataplexy and intellectual deterioration for plethysmography. Sleep studies are generally not recommended for insomnia of any kind unless there is sleep disordered breathing, failure of insomnia treatments or precipitous arousals with injurious behavior documented. In this case, there is no documentation of such conditions and the request for sleep studies is not medically necessary and appropriate.

**Functional capacity evaluation, Qty 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd edition 2004, pg 137-138.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**Decision rationale:** Guidelines note that there is little scientific evidence confirming FCEs predict an individual's actual capacity to perform in the workplace. There is no documentation that the patient is at maximum medical improvement. The request for a functional capacity evaluation is not medically necessary and appropriate.