

<b>Case Number:</b>	CM13-0040540		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	09/17/2005
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 48 years old male with an injury date on 09/17/2005. Based on the 06/20/2013 progress report provided by [REDACTED], the diagnoses are Gastropathy + IBS + insomnia, Depression + HTN and LT inguinal hernia + Ortho condition. According to this report, the patient complains of low back and leg pain that is a 10/10 on the pain scale. The patient's walking has worsened markedly and he is now using a motorized wheelchair. The 08/05/2013 hand written report indicates pain is at a 9/10 at the low back and patient is wheelchair bound. Physical exam finding were not included in the reports provided. There were no other significant findings noted on this report. The utilization review denied the request on 09/23/2013. [REDACTED] is the requesting provider, and he provided treatment reports from 06/20/2013 to 08/05/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REGULAR WHEELCHAIR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MTUS AETNA Guidelines, Clinical Policy Bulletin Number 0271, Manual Wheelchairs.

**Decision rationale:** ODG guidelines support the use of a manual wheelchair if prescribed by the treating physician. ODG does not go into any criteria or indications for medical necessity of a manual wheelchair. There does appear to be documentation of difficulty with walking in this patient but no details regarding mobility at home. AETNA guidelines deems a manual wheelchair medically necessary when the patient is unable to perform mobility-related activities of daily living (ADL's) at home. In this case, there is no documentation that the patient has difficulty handling mobility-related ADL's at home. The list of diagnosis do not show any mobility issues other than chronic pain. As such, the request is not medically necessary.

**TRIAL OF AQUATIC THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY ,.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines aquatic therapy; Physical Medicine Page(s): 22; 98, 99.

**Decision rationale:** MTUS guidelines recommend aquatic therapy as an option for land-based PT in patients that could benefit from decreased weight-bearing. The MTUS physical medicine section states that 8-10 sessions of physical therapy are indicated for various myalgias and neuralgias. Review of the reports do not discuss why weight reduced exercise would benefit this patient, and there is no documentation regarding extreme obesity. There is no discussion as to what is to be accomplished with therapy. Given no recent therapy history, a short course of therapy may be reasonable to address flare-up's or change in clinical presentation. However, the requested aquatic therapy but does not mention duration and frequency of the request. As such, the request is not medically necessary.

**TRIAL OF PERCUTANEOUS SPINAL CORD STIMULATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SPINAL CORD STIMULATION ,.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

**Decision rationale:** MTUS guidelines recommend spinal cord stimulators only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions, such as failed back syndrome, Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), Post amputation pain, Spinal cord injury dyesthesias, pain associated with multiple sclerosis and peripheral vascular disease. Review of the reports does not show that the patient has failed back surgery syndrome or other diagnosis that would warrant

a spinal stimulation trial. There is no discussion regarding psychological evaluation either. As such, the request is not medically necessary.

**TRIAL OF INTRATHECAL MORPHINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTRATHECAL PAIN PUMP.

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

**Decision rationale:** ODG Guidelines states this form of pain control is recommended only as an end-stage treatment alternative for selected patients for specific conditions after failure of at least 6 months of less invasive methods and following a successful temporary trial. Indications for implantable drug delivery system when it is used for the treatment of non-malignant pain with a duration of greater than six months and all of the following criteria are met: 1) Documentation in the medical records of failure of 6 months of other conservative treatment modalities, 2) Intractable pain secondary to a disease state with objective documentation of pathology, 3) Further surgical intervention or other treatment is not indicated, 4) Psychological lab evaluation had been obtained, 5) No contraindications to implantation, and 6) A temporary trial of spinal epidural or intrathecal opiates have been successful prior to permanent implantation with at least 50% to 70% reduction in pain. In this case, the treater provides no indication of the efficacy or lack of efficacy of the pain medication. In addition, there is no psychological evaluation and no objective documentation of a disease state with objective documentation of pathology. As such, the request is not medically necessary.