

Case Number:	CM13-0037967		
Date Assigned:	12/18/2013	Date of Injury:	11/02/2004
Decision Date:	03/03/2015	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/24/2013

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 53 year old male sustained work related industrial injuries on November 2, 2004. The mechanism of injury was not described. The injured worker subsequently complained of right shoulder pain and low back pain. Treatment consisted of radiographic imaging, prescribed medications, consultations and periodic follow up visits. MRI of the right shoulder on June 19, 2013 revealed soft tissue anchors in humeral head consistent with rotator cuff repair. Adjacent postsurgical subcutaneous scar tissue was noted. There was intermediate intrasubstance signal within the supraspinatus and subscapularis tendons, consistent with tendonosis. MRI of the lumbar spine on June 19, 2013, revealed interbody fusion and bilateral laminectomies at L4-5 and L5-S1 and bilateral posterolateral osseous fusion. Per most recent treating provider report dated July 29, 2013, the injured worker reported having more episodes of leg giving out with increased muscle spasms. The injured worker reported that the pain medication had been causing him to be nauseated. Physical exam of the right shoulder revealed painful range of motion, forward flexion and abduction to 90 degrees and tenderness to palpation of AC Joint. Lumbar spine exam revealed spasm, painful and limited range of motion. There was a positive bilateral Lasague test and straight leg test at 45 degrees. There was motor weakness noted bilaterally at 4/5 and a decreased sensation on the left at L4-5 and L5-S1. The injured worker's diagnoses included status post lumbar fusion and status post right shoulder surgery. As of July 29, 2013, the injured worker remains permanent and stationary. The treating physician prescribed services for manual wheelchair now under review. On September 24, 2013, the Utilization Review (UR)

evaluated the prescription for manual wheelchair requested on September 16, 2013. Upon review of the clinical information, UR non-certified the request for manual wheelchair, noting the lack of sufficient clinical documentation to support medical necessity for requested wheelchair, and the recommendations of the Official Disability Guidelines. This UR decision was subsequently appealed to the Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MANUAL WHEELCHAIR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg, Wheelchair and Immobilization

Decision rationale: ODG states Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair. (CMS, 2007) For powered wheelchairs, see Power mobility devices (PMDs).ODG states concerning Immobilization Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. The treating physician does not document a reason for the patient's leg instability. The treating physician notes motor weakness of 4/5 but does not detail focal neurologic deficits or a medical cause of the leg weakness. In addition, the treating physician does not detail a treatment plan to diagnose the cause of the leg weakness and treatment options. ODG recommends against immobilization of the lower extremities. The treating physician has not met the above guidelines. .