

<b>Case Number:</b>	CM15-0141564		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	02/07/2004
<b>Decision Date:</b>	08/28/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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: Arizona, California  
 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 is a 56 year old male with a February 7, 2004 date of injury. A progress note dated June 12, 2015 documents subjective complaints (pain in the bilateral shoulders, elbows, and wrists; cramping, numbing, sharp, throbbing, tingling, muscle spasms, swelling, and loss of feeling in the bilateral upper extremities; pain radiates to the back, bilateral upper extremities, bilateral lower extremities, bilateral buttocks, and head; pain rated at a level of 9 out of 10; dependence on others for activities of daily living; feeling blue all of the time; non-restful sleep; recent history of falls; feeling weak and increased pain to his whole upper body from the waist up), objective findings (decreased grip strength bilaterally; limited active range of motion of the cervical spine; antalgic gait; decreased sensation to the right arm; decreased range of motion of the shoulders; positive impingement test; dressing intact to low and mid back with no active bleeding or drainage noted), and current diagnoses (cervical spondylosis without myelopathy; medial epicondylitis of the elbow; unspecified disorders of the bursae and tendons of the shoulder region; unspecified myalgia and myositis; cervical spine stenosis). Treatments to date have included medications, intrathecal pump, use of a wheelchair and assistive device, and imaging studies. The treating physician documented a plan of care that included twelve sessions of aqua therapy for the bilateral shoulders and neck, and a lightweight wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Sessions of aqua therapy for the bilateral shoulders and neck: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Neck and Upper Back (Acute & Chronic), Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines aquatherapy Page(s): 22.

**Decision rationale:** Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The length of treatment recommended is up to 8 sessions. In this case, there is inability to perform exercises due to back pain and unstable gait as well as weight gain. However, response to an initial 8 sessions is not known. The amount requested exceeds the amount suggested by the guidelines. The request above is not medically necessary.

**1 Light weight wheelchair: Overturned**

**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) knee chapter and pg 71.

**Decision rationale:** According to the guidelines, a manual wheelchair is 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. In this case, the claimant has difficulty with gait and pain. The request for a wheelchair is medically necessary.