

Case Number:	CM15-0116826		
Date Assigned:	06/25/2015	Date of Injury:	03/09/2011
Decision Date:	07/24/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/17/2015

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 Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 54 year old female who sustained an industrial injury on 3/9/11 in a twisting incident causing her back to go numb followed by severe pain where she could not walk. She was medically evaluated and treated conservatively. She had a lumbar epidural steroid injection. Surgery was recommended and denied and psychiatric evaluation was suggested due to anxiety and depression related to ongoing pain and lack of treatment. She currently complains of daily lower back pain with radiation down the upper buttocks (8/10); neck pain and numbness with numbness radiating down the bilateral upper extremities. She has an antalgic gait and uses a seated walker for ambulation. On physical exam, there was tenderness across the upper buttocks, sacroiliac joint, bilaterally and centrally across the lower lumbar spine, decreased sensation over the left L4 dermatome distribution. Faber's and Fortin's were positive bilaterally. Medications are Norco, Soma, ibuprofen, omeprazole, Restoril, amitriptyline, citalopram, lorazepam, Sennalax-s. Diagnoses include disc degeneration at C5-6, C6-7; lumbar spondylosis; bilateral sacroiliac joint dysfunction; L3-S1 facet arthropathy, status post radiofrequency ablation; chronic intractable pain. Treatments to date include lumbar radiofrequency ablation L3, 4, 5, and S1 (12/1/14) with complete resolution of throbbing pain; medications; lifestyle modification; physical therapy; sacroiliac joint block (10/2014). Diagnostics include MRI of the lumbar spine (2/10/15) showing severe facet arthropathy, mild lateral recess stenosis L3-4 and L4-5; x-ray of the lumbar spine (6/16/14) showing sclerosis along the sacroiliac joints bilaterally; MRI of the lumbar spine (12/20/12) showing disc desiccation throughout the lumbar spine; electromyography/ nerve conduction study (11/28/11) showing evidence of large fiber polyneuropathy. In the progress note dated 5/22/15 the treating provider's plan of care includes a request for wheelchair rental for six months due to extreme pain with ambulation and increased fall risk.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wheelchair standard (in months) QTY: 6.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelchair. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Wheelchair "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 largest 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 from those 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)." There is no documentation that the patient has a mobility deficit with a cane or a walker and the need for a wheelchair is not clear. There is no documentation the patient is confined to her room or bed. Therefore, the request is not medically necessary.