

<b>Case Number:</b>	CM15-0170867		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	08/09/2010
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 67 year old male, who sustained an industrial injury on 8-9-10. The injured worker was diagnosed as having disorder of coccyx, mood disorder, low back pain, lumbar radiculopathy and pain disorder. Treatment to date has included oral medications including Dexilant Dr 60mg, Lyrica 200mg, Cymbalta 60mg, Neurontin 600mg, Oxycodone 15mg, Soma 350mg, Ambien Cr 12.5mg, Lyrical 100 mg, Oxycontin 20mg, Oxycontin 10mg, Seroquel 50mg, Oxycodone 15mg, Oxycodone 30mg, Medrol 4mg, Plavix and Seroquel 100mg; topical Flector 1.3% patch, Lidoderm 5% patch; deep tissue massage, coccyx injection, spinal cord stimulator, physical therapy and activity modifications. On 6-29-15 and again on 7-27-15, the injured worker complains of pain rated 7 out of 10 with medications and 10 out of 10 without medications with poor sleep quality. He notes he gets dressed in the morning and does minimal activities at home. He is not currently working. Physical exam performed on 7-27-15 noted restricted range of motion of lumbar spine, antalgic gait, tenderness over the coccyx and hypertonicity, tenderness and trigger points on palpation of paravertebral muscles. An undated request for authorization was submitted for physical therapy 2 times a week for 7 weeks, aquatic therapy for 2-3 times a week for 4-6 weeks and a wheelchair. On 7-31-15, utilization review non-certified a request for physical therapy 2 times a week for 7 weeks, aquatic therapy for 2-3 times a week for 4-6 weeks noting the date of injury was 8-9-10 and the injured has reasonably participated in extensive physical therapy in the past; however the number of sessions completed and functional relief/improvement are not documented and non-certified a request for a wheelchair noting it is unclear if this is a replacement wheelchair.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 x 6 weeks (Aquatic/Pool therapy 2-3x/week for 4-6 weeks) for total of 12 visits for low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. In this case, the injured worker has participated in an unknown amount of physical therapy for an unknown period of time without documentation of the benefits derived from the therapy. It is unclear, from the available documentation, why the injured worker cannot participate in a home-directed, self-paced exercise program. There is also no documentation suggesting that the injured worker cannot tolerate weight bearing activities. This request for 12 sessions exceeds the recommendations of the established guidelines. The request for physical therapy 2 x 6 weeks (aquatic/pool therapy 2-3x/week for 4-6 weeks) for total of 12 visits for low back is determined to not be medically necessary.

**Wheelchair with wide seat:** 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 and Leg, Wheelchair.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter/Wheelchair Section.

**Decision rationale:** The MTUS guidelines do not address the use of wheelchairs, therefore, alternative guidelines were consulted. Per the MTUS guidelines, wheelchairs are recommended 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. In this case, it is unclear why the physician is requesting this wheelchair as the injured worker is stated to have a wheelchair. It is also unclear if this request is for a manual wheelchair or a powered wheelchair. Without this information, a positive determination cannot be made. The request for wheelchair with wide seat is determined to not be medically necessary.