

Case Number:	CM15-0095708		
Date Assigned:	05/22/2015	Date of Injury:	10/26/2009
Decision Date:	08/18/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/18/2015

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 55 year old male who sustained an industrial injury on 10-26-09. Diagnoses are paraplegia, left scapular and left shoulder pain. In a progress report dated 2-19-15, the treating physician notes the injured worker is still working. Naproxen is noted for shoulder pain. Daily leg burning is rated as 8 out of 10, spasticity is noted as well. Daily back pain is rated at 8 out of 10. Parts of the handwritten note are illegible, but the following medications are noted; Pamelor and Baclofen. the treatment plan is that he may need a power assist wheelchair secondary to increased shoulder pain, spasticity is better, pain is controlled with medications, and review x-ray reports. A written prescription dated 4-6-14 notes 1) replace wheelchair seat cushion and 2) repair back pad of wheelchair. Radiographs of the lumbar spine dated 2-5-15 notes history of back pain and reveals five lumbar type vertebral bodies are noted. Prior surgical fusion of the thoracolumbar junction of the spine is noted. T12, L1 and L2 transpedicular bone screws appear well seated. Lumbar lordotic curvature is maintained. Intervertebral disc space narrowing is noted at the L2-3 greater than L3-4, L4-5 and L5-S1 levels. Multilevel posterior facet hypertrophic degenerative changes are most pronounced at L3-4, L4-5 and L5-S1. No pars articularis defects are seen. Atherosclerotic calcifications of the abdominal aorta noted without aneurysmal dilation. The impression is: prior surgical stabilization of the thoracolumbar junction of the spine. The visualized hardware appears well seated without evident complication and multilevel degenerative changes of the lower lumbar spine with disc space narrowing and posterior facet hypertrophic degenerative changes. Xrays of the thoracic spine done 2-5-15 notes a history of back pain, spinal trauma with thoracolumbar fusion in 2009. The findings are

thoracolumbar surgical stabilization is noted with T9, T10, T11, T12 and L1 transpedicular bone screws with posterior stabilization rods. Mild anterior foreshortening of the T12 vertebral body appears stable. Multilevel intervertebral disc space narrowing with anterior and predominantly right lateral non marginal osteophyte formation is noted. These osteophytic degenerative changes are most pronounced at T6-7 and T7-8 fractures. Healed right posterolateral rib fractures are noted. Right hip x-rays done 2-5-15 reveal mild degenerative changes of the right hip. The requested treatment is a manual wheelchair for purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual wheelchair for purchase: 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, 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 manual wheelchairs, therefore, alternative guidelines were consulted. The ODG recommends the use of a manual wheelchair if the patient requires it and will use it 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, the injured worker suffered an injury to the spine and using a wheelchair for getting around. The available documentation states only that the pad on the wheelchair needs replaced but lacks information about the rest of the wheelchair and why an entirely new wheelchair is needed. The request for manual wheelchair for purchase is determined to not be medically necessary.