

<b>Case Number:</b>	CM13-0007559		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	08/26/2011
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 37 year old male claimant sustained a fall injury on 8/26/10 resulting in a right hip injury and resultant complex regional pain syndrome with intense pain in the right and left lower extremities. A CT of the pelvis showed no fractures and an MRI of the lumbar spine showed no spinal stenosis or herniation. He has had a clot removed from his left hip. His pain has been managed with oral analgesics, muscle relaxants and tricyclics. He has been using a wheelchair to transport himself. Due to difficulty maneuvering and leg twisting, his treating physician on 7/1/13 requested a motorized wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Q-6 Edge Electric Mobility Chair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter.

**Decision rationale:** According to the MTUS and ODG guidelines, power mobility devices (PMD) are not recommended if the functional mobility deficit can be sufficiently resolved by the

prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, there is no documentation of examination that would indicate the shoulders and arms are not able to adequately perform mobility required with a standard wheelchair. There is no mention of lack of any caregiver that can help during times of leg twisting. As a result a motorized wheel chair is not medically necessary.