

<b>Case Number:</b>	CM13-0017204		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	03/17/1993
<b>Decision Date:</b>	01/21/2014	<b>UR Denial Date:</b>	08/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2013

### 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 physical medicine and rehabilitation and is licensed to practice in Illinois, Indiana, and Texas 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.

### 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 patient is a 65-year-old male who reported an injury on 03/17/1993. The mechanism of injury was not provided for review. The patient underwent a remote L2-3 fusion. It was noted within the documentation that the patient used an electric wheelchair, and various braces on the wrist, elbows, left ankle-foot orthosis, and lumbar support. The patient's most recent clinical evaluation stated that the patient's current electric wheelchair was malfunctioning and unable to be repaired. It is noted within the documentation that the patient has a very limited upper extremity use, and very limited ability to perform successful transfers and repositioning. A replacement chair was part of the patient's continued treatment plan.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Invacare Arrow power wheelchair:** Overturned

**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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** Clinical documentation submitted for review does provide evidence that the patient's current electric power mobility device is irreparably damaged. Therefore, a replacement would be indicated. The Chronic Pain Medical Treatment Guidelines does not recommend a power mobility device if a functional mobility deficit cannot be sufficiently be resolved with

lower levels of equipment. However, the clinical documentation submitted for review does indicate that the patient has been dependent for mobility on the previous electric power chair. Additionally, it is noted that the patient has a very limited upper extremity use due to significant chronic pain. The clinical documentation submitted for review does support that the patient has bilateral upper extremity braces that would interfere with the ability to use a manual wheelchair. The request for Invacare Arrow power wheelchair would be medically necessary and appropriate.

**Invacare power wheelchair motorized with power recline system:** Overturned

**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:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs) Section Page(s): 99.

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has a limited capacity to perform a transfer or functional weight shift. A recline seating system would assist with this, as the patient is essentially non-ambulatory and will be in the chair for an extended duration throughout the day. The Chronic Pain Medical Treatment Guidelines does not recommend power mobility equipment when the patient's functional mobility deficit can be resolved with lower levels of equipment. The clinical documentation submitted for review does indicate that this is a replacement chair for a patient who has been dependent on power mobility for an extended duration of time. The request for Invacare power wheelchair motorized with power recline system is medically necessary and appropriate.

**Invacare power chair, motorized wheelchair with electronic interface and EZ Lock mount:** Overturned

**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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has to replace the current seating system, as the prior seating system is no longer functional or manufactured. California Medical Treatment Utilization Schedule does not recommend power mobility devices in the absence of a patient's functional abilities to be sufficiently resolved with lower levels of equipment. The clinical documentation submitted for review does provide evidence that the patient is dependent on his current power mobility device for ambulation. It is noted within the documentation that the patient's current chair has an electronic interface and EZ Lock mount to assist in safe transportation. As the patient is unable to easily transfer in and out of the power mobility device, this would be medically necessary. The requested Invacare power chair, motorized wheelchair with electronic interface and EZ Lock mount is medically necessary and appropriate.

