

Case Number:	CM13-0019865		
Date Assigned:	12/18/2013	Date of Injury:	09/01/2010
Decision Date:	01/31/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/04/2013

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 Practice, has a subspecialty in Texas and is licensed to practice in. 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:

The patient is a 35 year old female who reported in injury on 09/01/2010. The mechanism of injury information was not provided in the medical record. The patient diagnosis included lower extremity complex regional pain syndrome, psychogenic pain, and chronic pain. Review of the medical records revealed the patient was most recently seen by her physician on 08/05/2013 for lower extremity chronic pain and reflex sympathetic dystrophy with both sleep and mood disorder. Physical assessment of the patient revealed the patient ambulated without assistance, and had antalgic gait. The patient exhibited no signs of distress. Medication regimen included Zoloft 50mg 1 tablet daily, Flector 1.3% Patch 1 patch applied twice daily, and Celebrex 100mg 1 capsule twice daily.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized wheelchair: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Power mobility devices (PMDs).

Decision rationale: California MTUS ACOEM does not address motorized wheelchairs. Official Disability Guidelines state power mobility devices 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. There are no objective clinical findings noted in the medical record suggestive that the patient has any deficits with her upper extremities that would prevent her from being able to properly use a cane or walker. At the most recent clinical office visit the patient was able to ambulate well without pain and no assistance. As such there is no medical necessity for the motorized wheelchair. Therefore, the request for motorized wheelchair is non-certified.