

Case Number:	CM13-0045075		
Date Assigned:	12/27/2013	Date of Injury:	12/08/2005
Decision Date:	02/21/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/30/2013

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 & Rehabilitation 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 is a male patient with a date of injury of 12/8/05. A utilization review determination dated 10/7/13 recommends non-certification of an electric wheelchair. A progress report dated 9/24/13 identifies subjective complaints including low back pain 8/10 with numbness and tingling radiating down the right leg into the medial aspect of the right ankle. He is currently using a cane, walker, and wheelchair. Objective examination findings identify positive Stoop test, walks with a cane, unable to straighten his lumbar spine, hips, or knees completely. There is paraspinal tenderness, and he is unable to toe and heel walk due to his drop foot. Positive straight leg rising bilaterally at 10 degrees causing spasms in his lower back. Seated sciatic nerve stretch test is positive bilaterally. He is unable to dorsiflex his right foot or raise his right great toe against resistance. He has an extremely antalgic gait. Lumbar ROM is significantly limited. Diagnoses include drop foot right, multilevel lumbar spine stenosis, disc protrusions, and arthropathy, and L5-S1 radiculopathy. Treatment plan recommends a power wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

One electric 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, Knee & Leg (Acute & Chronic).

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

Decision rationale: Regarding the request for electric wheelchair, the MTUS Chronic Pain Guidelines indicate that 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. They also note that 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. Within the documentation available for review, there is documentation that the patient is utilizing a cane, walker, and wheelchair, and there is no documentation identifying why these devices are no longer able to address his mobility deficits. In the absence of such documentation, the currently requested electric wheelchair is not medically necessary.