

<b>Case Number:</b>	CM13-0068089		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/05/1995
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. 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/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 injured worker is a 60-year-old female who reported an injury on 06/05/1995, secondary to a fall. Current diagnoses include localized osteoarthritis of the lower leg and unspecified internal derangement of the knee. The injured worker is also status post above-the-knee amputation of the right knee. The latest physician progress report submitted for this review is documented on 09/06/2013. The injured worker reported persistent left knee pain. Physical examination revealed painful arthritis left knee. Treatment recommendations included an electric wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 ELECTRIC WHEELCHAIR 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 - Treatment For Worker's Compensation, Online Edition, Chapter: Knee And Leg, Wheelchair.

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

**Decision rationale:** California MTUS Guidelines state power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by a prescription of a cane or a walker, or the injured worker has sufficient upper extremity function to propel a

manual wheelchair, or there is a caregiver who is available and willing to provide assistance with a manual wheelchair. There is no indication that this injured worker has insufficient upper extremity function to propel a manual wheelchair. There is also no indication that this injured worker does not maintain assistance from a caregiver. Therefore, the medical necessity had not been established. As such, the request is not medically necessary.