

<b>Case Number:</b>	CM13-0069654		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/12/2006
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2013

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 patient is a 45-year-old female who reported an injury on 05/12/2006. The mechanism of injury was not stated. The patient is diagnosed with lumbosacral spondylosis without myelopathy, displacement of cervical intervertebral disc without myelopathy, cervical spondylosis without myelopathy, degeneration of cervical intervertebral disc, opioid-type dependence, pathologic fracture of the vertebrae, and primary localized osteoarthritis. The patient was seen by [REDACTED] on 12/04/2013. The patient reported 8/10 pain to the cervical spine, mid back, and radiation into bilateral upper extremities. The patient reported increased mobility and function with the current medication regimen. Physical examination revealed limited cervical range of motion, 4/5 strength, 5/5 grip strength, intact sensation, and increased elbow range of motion. Treatment recommendations at that time included a request for a power wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POWER OPERATED WHEELCHAIR (PURCHASE OR RENTAL):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

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

**Decision rationale:** The California MTUS 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. As per the documentation submitted, the patient currently utilizes a manual wheelchair. The patient's physical examination on the requesting date revealed 5/5 grip strength, 4/5 upper extremity strength, and increasing range of motion in bilateral elbows. There is no evidence of a functional mobility deficit that cannot be resolved by the prescription of a cane or walker. There is no evidence of insufficient upper extremity function. Therefore, the medical necessity for the requested durable medical equipment has not been established. As such, the request is non-certified.