

Case Number:	CM14-0006353		
Date Assigned:	01/22/2014	Date of Injury:	01/09/2013
Decision Date:	04/02/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/16/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working least at 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 42 year old female that reported a work injury on 01/19/2013. The mechanism of injury was reported as the patient being hit directly in the lower back by a door knob as she walked thru the door. On the clinical note dated 04/02/2013, the patient reported that she had immediate pain to her lower back. The pain is reported as ongoing seven days a week and was reported as a 9/10. The medication the patient is currently on is Cymbalta, lamotrigine, Wellbutrin, and occasional Abilify and Celebrex, with Ultram for pain, with a new prescription of Percocet 5/325 mg. The patient complained of difficulties weakness with bowel and bladder function with complete loss of sensation to the perineal area. The patient has tenderness to the paraspinal muscle of the lumbar spinal on the right side with noted flex of 30 degrees, extension of 5 degrees, left lateral bend to 15 degrees and right lateral bend to 10 degrees. The patient has pain intensity. The patient uses a walker to ambulate. The patient has a diagnosis of Thrombocytopenia-absent radius syndrome as well as a history of low back pain starting in 2002 from a previous job injury that was resolved. The clinical report dated 11/14/2013 the patient has complaints of pain that rate 9/10 without the patient's pain medication of Percocet 10/325 mg, which the patient is taking 1 five times a day, Neurontin 300 mg three times a day, Dexilant capsules 1 a day as needed for gastrointestinal symptoms, Lidoderm patches, Flexeril 10 mg 1 daily, Tegaderm patches, and other psychotropic medications. The clinical note states that an MRI done on 10/12/2013 showed disk desiccation at L1-L2 and Schmorl's nodes at the superior endplate of L4 and L2. Facet joint is mildly arthritic on the left side of L5-L1

IMR ISSUES, DECISIONS AND RATIONALES

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

Car attachment to transport electric wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter, Power mobility devices (PMDs), Knee and Leg, Durable medical equipment (DME)

Decision rationale: The request for the chair lift for the electric wheel chair is non-certified. The patient has long standing pain to her lumbar spine since 2002 that was resolved then she re-injured her lower spine on 01/19/2013. The patient is now walking with a walker with assistance and using an electric wheelchair that she is requesting a lift for her vehicle to help with her mobility. The Official Disability Guidelines state a powered mobility device is not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker. The Official Disability Guidelines state that it recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment which states the device can withstand repeated use, i.e., could normally be rented, and used by successive patients; or Is primarily and customarily used to serve a medical purpose; or generally is not useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. The patient is noted to currently be using a walker for assistance and the information provided failed to indicate this was not of adequate benefit. Therefore, given a powered mobility device is not supported, the Car attachment to transport electric wheelchair is not supported. As such, the request for the lift is non-certified