MAXIMUS Federal Services

Case Number:	CM14-0006497		
Date Assigned:	03/03/2014	Date of Injury:	09/30/2009
Decision Date:	06/30/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/16/2014

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 Occupational Medicine 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 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 31 year old male who was injured on 09/30/2009. The patient was cleaning grafitti on a train station and was hit by at train. Prior treatment history has included T10-L1 minimally invasive posterior spine instrumentation on 10/09/2009 and on 10/16/2009, he had a T11-L1 direct lateral interbody fusion. PR2 dated 10/30/2013 indicates the patient reports increased accessibility, but still needs a home evaluation to assess the need for modifications and adaptations as he has moved to [redacted]. Since the patient has moved, the patient needs a new clinician for massage therapy. It states in the report that his chair has been repaired and is awaiting authorization for a new power chair. The patient continues with intermittent catheterization but he is having no further episodes of hematuria. He reported less difficulty with sphincter spasms when cathing and he was started on Vesicare. The patient's bowel program is digital stimulation and only p.r.n. He was having no incontinence or impaction. On exam, range of motion is functional in the bilateral upper and lower extremities. His tone reveals Ashworth I of bilateral lower extremities. On motor exam, bilateral upper extremities are 5/5 and bilateral lower extremity is 0/5. He had less subacromial tenderness. The diagnoses are 1) Status post work related injury on 09/13/2009 2) Pedestrian versus train 3) T11, T12 fracture, dislocation with associated retrolisthesis and canal involvement 4) History of chest tube, status post removal 5) History of left apical pneumothorax 6) History of multiple skin wounds 7) History of right two front teeth trauma 8) L1 paraplegia, ASIA A 9) Neurogenic bladder 10) Neurogenic bowel 11) Neuropathic and musculoskeletal pain 12) History of head trauma and loss of consciousness 13) History of right lower extremity DVT, status post Coumadin treatment and 14) Back and shoulder pain worsened, myofascial, RTC. The patient has paraplegia and uses his upper extremities for all mobility of propelling wheelchair, transferring in and out of wheelchair and ADL's. The patient developed overuse complications of bilateral shoulder and is requiring

treatment by an orthopedic MD and physical therapy. It is a medical necessity that the patient preserves his upper extremity and shoulder strength by using a power wheelchair for long distance mobility and during episodes of shoulder pain exacerbation. The Prior Utilization Review (UR) dated 12/31/2013 states the request for a wheelchair repair/replacement is not medically necessary and appropriate as there is no clear indication as to the type of chair that is being requested, why the chair is needed and proper documentation as it pertains to cost management.

IMR ISSUES, DECISIONS AND RATIONALES

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

WHEELCHAIR REPAIR/REPLACE: Overturned

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 Page(s): 99.

Decision rationale: According to MTUS guidelines, power mobility devices are not recommended if the patient has sufficient upper extremity strength to power a manual wheelchair. The patient is a 31 year old who became paraplegic after a 9/30/09 injury in which he was struck by a train. The patient reportedly developed B shoulder repetitive use disorder from operating a manual wheelchair, and a power wheelchair is requested for episodes of upper extremity pain. Upper extremity strength was noted to be 5/5 though the patient is treating with an orthopedist for bilateral shoulder impingement syndrome confirmed by MRI's done on 10/16/13. Medical necessity is established for a power wheelchair, either a new one or repair of an existing power wheelchair, given the patient's bilateral shoulder injuries, which are documented to be caused and aggravated by manual wheelchair use.