

Case Number:	CM14-0014448		
Date Assigned:	02/28/2014	Date of Injury:	02/20/2007
Decision Date:	06/27/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	02/05/2014

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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 62-year-old male who reported an injury on 02/20/2007 with the mechanism of injury not provided in the documentation. In the clinical note dated 12/11/2013, the injured worker complained of back pain with bad left sciatica. It was noted that there was no significant change with his knee and hip problems. It was also noted that the injured worker continued to lose weight and was close to the limit to qualify for hip surgery. It was noted that the injured worker was in extreme pain with the low back, hip, knee and left sciatica. In the physical exam of the hip, it was noted that both hips had limited range of motion and tenderness in the left hip when doing range of motion. In the physical examination of the knees, the left knee revealed reduced range of motion with tenderness and mild edema. In the physical examination of the back, it was noted to be tender to palpation with reduced range of motion. The neurological examination revealed decreased sensation to both legs with no significant weakness to the legs but the examination was difficult due to knee and hip problems. The diagnoses included right knee osteoarthritis status post total knee replacement, left knee severe osteoarthritis, left hip severe osteoarthritis, low back pain with radicular pain and a history of GI bleeding. In the treatment plan/discussion, it was noted that the injured worker was losing weight with [REDACTED] surgery and it was noted that the injured worker stated that he planned to have a left total knee replacement when his weight was down to 250 pounds. The treatment plan also included dental care, a left shoulder MRI to help the diagnosis, a request for an L5-S1 ESI for pain relief, a manual wheelchair for short distance and a power scooter for long distance, a request for aquatic therapy, a continuation of Oxycodone 30 mg, Protonix 20 mg and Ultram ER, topical cream, Sentra PM and continuation of Ambien 10 mg and to return to the clinic in 4 weeks. The request for authorization for the manual wheelchair was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MANUAL 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 (ODG) Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg (acute and chronic), Wheelchair, Durable medical equipment (DME).

Decision rationale: The request for a manual wheelchair is not medically necessary. The Official Disability Guidelines (ODG) state that a wheelchair is recommended if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. The ODG also states that wheelchair is recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) which includes withstanding repeated use, i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; & is appropriate for use in a patient's home. In the clinical notes provided for review, it was unclear of the rationale for the request of a manual wheelchair. It was noted that the injured worker had pain to the low back, hip, knee and left sciatica. However, in the physical examination it was noted that there was no significant weakness with the legs. The rationale for the request of a manual wheelchair was not evident in the documentation provided. The guidelines state that a wheelchair is recommended if there is a medical need. However, in the clinical notes provided, there is a lack of evidence of the need for a manual wheelchair. Therefore, the request for a manual wheelchair is not medically necessary.