

<b>Case Number:</b>	CM14-0017156		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	03/11/2013
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2014

### 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 Internal 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:

Progress report January 14, 2014 was provided by [REDACTED]. Date of injury 03/11/2013. Interim History: Patient is here for follow-up of her left shoulder, low back, and left leg pain. She states today that she is also having some right leg symptoms. She ambulates today with a cane and is significantly painful. She states that she had two weeks of significant back pain and was unable to get out of bed. She is in a significant amount of pain today with noted stiffness in her walking. She denies any bowel or bladder incontinence. She states that everything is just significantly painful. She is having difficulty getting around and is requesting a back brace as well as wheelchair. Physical Examination: Jamar Testing: Right Hand: 0/0/0, Left Hand: unable to do. Right Hand Dominant. Motor exam on the right side shows weakness of 3+ to 4-/5 in all muscle groups. The left side is 3/5 in all muscle groups. She states that she has difficulty with putting any weight on her left side. She is significantly limited due to pain and effort today in her muscle testing. Sensation is unchanged from last visit. Straight leg raise on both sides elicits pretty significant back pain with some radiation of pain into her knees. The left arm examination shows immobility of the left arm. There is no motion noted in her shoulder due to it being significantly stiff. Assessment: 1. Status post work-related slip and fall on March 11, 2013. 2. L5-S1 disc herniation, status post discectomy, June of 2013. 3. Chronic low back and radiating left leg pain. 4. Neck sprain/strain. 5. Left shoulder sprain/strain, frozen shoulder, rule out internal derangement. Discussion/Plan: Patient continues to have persistent significant symptoms. At this point in time we will give her some medications to help decrease her pain. I have given her exercises; however, she states that she is unable to do so due to her pain. As she is unstable on her feet, I recommend a short rental of a wheelchair for four to six weeks as well as back brace for better support of her lumbar spine until further treatment for her low back can be

delineated. Request for authorization 01-27-2014 requested wheelchair. Utilization review decision date was 01-31-2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**DME WHEELCHAIR:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical treatment utilization schedule (MTUS) does not address wheelchair. \_\_\_ Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Wheelchair Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. \_\_\_.

**Decision rationale:** Medical treatment utilization schedule (MTUS) does not address wheelchair. The Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) addresses wheelchair. Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Progress report January 14, 2014 documented bilateral hand grip weakness, bilateral lower extremity weakness, back pain, left frozen shoulder. Patient is unstable on her feet. Bilateral hand and lower extremity motor weakness and gait instability makes a hand-held assistive device, such as a cane or walker, inadequate. The patient's bilateral hand grip weakness, bilateral lower extremity weakness, back pain, left frozen shoulder, and gait instability are physical examination findings that support the medical necessity of a wheelchair. Therefore, the request for DME Wheelchair is Medically Necessary.