

<b>Case Number:</b>	CM14-0018463		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	09/10/2010
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 and Rehabilitation, has a subspecialty in Interventional Spine 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 67 year-old female who was injured on 9/10/2010. She has been diagnosed with a chronic pain syndrome; and sciatic nerve lesion/piriformis syndrome. According to the 11/19/13 physiatry report from [REDACTED], the patient presents with right hip pain radiating to the right groin. She had an evaluation at [REDACTED] and was to be scheduled for right hip replacement surgery. The pain was 6-7/10. She takes Baclofen; oxycodone/APAP 10/325. The plan was for a right SI injection, right hip cortisone injection, and a manual wheelchair. On 2/7/14 UR denied the wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MANUAL 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, POWER MOBILITY DEVICES (PMDS),

**Decision rationale:** The patient presents with right hip pain radiating to the right groin, and is anticipating a right hip replacement surgery. She has an antalgic gait and has difficulty walking with a cane. The physician has requested a manual wheelchair. MTUS briefly mentions manual wheelchairs under "Powered mobility devices", stating that powered devices are not necessary if the functional deficit can be overcome with a walker or cane or if the patient has sufficient upper extremity function to propel a manual wheelchair. The patient has difficulty with the cane, but is suspected to have sufficient upper extremity strength to use a manual wheelchair. The request appears to be in accordance with MTUS guidelines.