

<b>Case Number:</b>	CM14-0122924		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	07/19/2002
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/04/2014

### 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 Family 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:

This is a 51-year-old male patient who reported an industrial injury to the back on 7/19/2002, over 12 years ago, attributed to the performance of his usual and customary job tasks reported as an electrocution. The patient complained of generalized weakness and headaches since the date of injury. The patient had previously received treatment with physical therapy and chiropractic care. The patient was evaluated on 7/8/2014 and complained of lower back pain. The patient presented in a wheelchair and reportedly had trouble getting in and out of the wheelchair. The patient was noted to be uncooperative for a physical examination and there were minimal objective findings documented on examination. The patient was diagnosed with chronic low back pain; electrocution and nonfatal effects of electrical current; and psychiatric mental status determination. The patient was treated with Polyethylene Glycol; Soma 350 mg; Alprazolam 0.25 mg; Omeprazole 20 mg; Norco 10/325 mg; and Fioricet for headaches. The patient was ordered a manual wheelchair for in-home use.

### 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

**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 Chapter - Wheelchair and Power Motility Devices Other Medical Treatment Guideline or Medical Evidence: Medicare guidelines for mobility devices

**Decision rationale:** The request for a mechanical wheel chair for use in the residence is not supported by objective evidence to demonstrate medical necessity and there is no rationale to support the medical necessity of a wheel chair for the treatment of the effects of the industrial injury. The objective findings on examination demonstrate that the patient does not meet the accepted criteria for a wheel chair on an industrial basis. The patient did not cooperate for physical examination and there were no demonstrated limitations to the bilateral lower extremity with any documentation of weakness or instability. The objective findings on examination documented no muscular issues, poor coordination, instability, or inability to ambulate. The patient presented in a wheelchair and was using the wheelchair as a convenience factor. The patient was not documented to be unable to utilize the cane. There is no documented deficit to warrant use of a wheelchair for community events or for inside the residence. It was recommended that the patient exercise more to provide lower body strength. There was insufficient subjective/objective evidence provided to support the medical necessity for the requested wheelchair for the treatment of the diagnoses listed when the patient is documented to ambulate without a walking aide for at least five minutes prior to fatigue. There were no objective findings of severe limited range of motion or an inability to walk with an aide or assistance. The patient is documented to have poor ambulation tolerance; however, this appears to be due to deconditioning and not to lower extremity impairments. The requesting provider has not demonstrated that a functional mobility deficit cannot be sufficiently resolved with the prescription of a cane or walker. The available documentation and diagnoses suggest that the patient has not met the recommended criteria for a wheelchair or the requested wheelchair according to the Official Disability Guidelines. The patient would be able to secure a wheelchair on her own for convenience issues; however, there is not demonstrated medical necessity for the effects of the industrial injury.