

Case Number:	CM14-0031041		
Date Assigned:	06/20/2014	Date of Injury:	02/23/2006
Decision Date:	07/17/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/12/2014

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, and is licensed to practice in Illinois. 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 58-year-old female with a reported injury on 02/23/2006. The mechanism of injury was not provided within the clinical notes. The clinical note dated 05/21/2014 reported that the injured worker complained of bilateral knee pain. Physical examination revealed edema to the lower extremities bilaterally. The injured worker's motor strength to the bilaterally lower extremities was reported as 5/5. The injured worker's diagnoses included osteoarthritis of the left knee, meniscal injury; chondromalacia, internal derangement; and lumbar spondylosis. The injured worker's prescribed medication list included oxycodone 30 mg every 6 hours as needed. The provider requested a shower chair and motorized wheelchair, indicating that the injured worker is unable to ambulate more than 100 feet at a time. The Request for Authorization was submitted on 02/26/2014. The injured worker's prior treatments included an inferior medial intra-articular joint injection of the left knee performed on 05/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shower Chair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute,LLC; Corpus Christi, TX; www.odg.twc.com; section Pain.

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

Decision rationale: The request for the shower chair is non-certified. The injured worker complained of bilateral knee pain. The treating physician's rationale for a shower chair was not provided within the clinical notes. The Official Disability Guidelines recommend Durable medical equipment (DME) generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). The term DME is defined as equipment which can withstand 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. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided. There was a lack of documentation indicating the injured worker had significant functional deficits requiring her to need a shower chair. Given the information provided, there is insufficient evidence to determine appropriateness to warrant the medical necessity. As such, the request is non-certified.

Motorized wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute,LLC; Corpus Christi, TX; www.odg.twc.com; section Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Power mobility devices (PMDs).

Decision rationale: The request for a motorized wheelchair is non-certified. The injured worker complained of bilateral knee pain. The treating physician's rationale for a motorized wheelchair was not provided within the clinical notes. The Official Disability Guidelines do not recommend power mobility devices (PMDs) if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided. There is a lack of documentation indicating the injured worker has significant functional deficits indicating the requirement of a motorized wheelchair. It is noted that the treating physician 'felt' that the injured worker would not be able to ambulated more than 100 feet at a time. There is a lack of clinical information indicating that the injured worker had a functional deficit preventing her from ambulating greater than 100 feet. Moreover, there is a lack of clinical information indicating an upper extremity functional deficit preventing the injured worker from propelling a manual wheelchair. As such, the request is non-certified.

