

Case Number:	CM14-0034041		
Date Assigned:	06/20/2014	Date of Injury:	01/28/1985
Decision Date:	11/26/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/18/2014

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 New Jersey & New York. 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 93 year-old male who was injured on 1/28/85 due to unknown mechanism. He complained of left hip pain. He was diagnosed with trochanteric bursitis and enthesopathy of the hip. He had left total hip replacement surgeries in 1984, 1988, and 1994 with acetabular osteolysis. He was treated with trochanteric steroid injections with great improvement in pain. He ambulated using a four wheel walker. On exam, the patient could shift from a seated to standing position with ease and able to move forward without discomfort. X-rays showed total hip in place, no osteolysis, loosening or evidence of polyethylene wear. Physical therapy was recommended but the patient did not wish to proceed with treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Power Wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

Decision rationale: The request for a power wheelchair is not medically necessary. According to MTUS, it is not recommended if the "functional mobility deficit can be sufficiently resolved by a

prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair." The patient was able to ambulate with a four wheel walker and able to transfer from a seated to standing position with ease and move forward without discomfort. If there is mobility with a walker, "a motorized scooter is not essential to care." Therefore, the request is considered not medically necessary.