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| <b>Case Number:</b>   | CM14-0041037 |                              |            |
| <b>Date Assigned:</b> | 06/30/2014   | <b>Date of Injury:</b>       | 05/21/1999 |
| <b>Decision Date:</b> | 08/25/2014   | <b>UR Denial Date:</b>       | 03/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/07/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 66-year-old female who has submitted a claim for cervical spinal stenosis with bilateral upper extremity, radiculopathy and associated cervicogenic headaches and lumbar myoligamentous injury. It is associated with an industrial injury date of 05/21/1999. Medical records from 08/04/2008 through 06/23/2014 were reviewed and showed that patient complained of neck pain (grade not specified) radiating into bilateral upper extremities, right greater than left, and thoracic and lumbar spine. Physical examination of the cervical spine revealed tenderness upon palpation over the posterior cervical muscles bilaterally. Numerous trigger points throughout the cervical paraspinal muscles were noted. Cervical spine ROM was decreased. There was decreased muscle strength in the right upper extremity compared to the left upper extremity. Deep Tendon Reflexes were intact for the upper extremities. Sensation to light touch was decreased in the right upper extremity compared to the left. Physical examination of the lumbar spine revealed tenderness over the lumbar muscles bilaterally. Decreased lumbar ROM was noted. Manuel Muscle Testing of bilateral lower extremities was 4+/5. Sensation to light touch was decreased over the lateral aspect of calves bilaterally. Deep Tendon Reflexes were 1+ for bilateral knee and ankle reflexes. MRI of the cervical spine dated 05/10/2010 revealed C5-6 disc space narrowing and marginal spurring. EMG study of the upper extremities dated 12/14/2000 revealed a right median nerve distal sensory neuropathy. Cervical spine MRI dated 07/17/2000 revealed C4-5, C5-6, and C6-7 spondylosis. Treatment to date has included cervical epidural steroid injection (09/27/2012), physical therapy, and pain medications. Utilization review dated 03/24/2014 denied the request for purchase of an electric wheelchair because there is inadequate evidence that manual wheelchair cannot have made adjustments to accommodate her for mobility.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of an electric wheelchair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility dDevices (PMDs) Page(s): 99.

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

**Decision rationale:** Page 99 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that power mobility devices (PMDs) are not recommended 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. If there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the patient has been using a manual wheelchair since at least 10/31/2013. Physical findings did not reveal significant upper extremity weakness, which is required by the guidelines to support the need for functional mobility with power mobility devices (PMDs). The medical necessity for electric wheelchair has not been established. Therefore, the request for purchase of an electric wheelchair is not medically necessary.