

<b>Case Number:</b>	CM14-0051859		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	11/02/2004
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 Occupational 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:

The patient is a 53-year-old female who has submitted a claim for associated bilateral shoulder impingement syndrome, cervical disc disease, lumbosacral disc disease, bilateral ankle sprain, bilateral Achilles tendonitis, bilateral carpal tunnel syndrome, bilateral wrist pains, and bilateral knee internal derangement with an industrial injury date of 11/02/2004. Medical records from 08/21/2007 to 07/15/2014 were reviewed and showed that patient complained of neck, back, bilateral shoulders, bilateral knees, bilateral ankles, and bilateral wrist pain (grades not specified). Physical examination revealed tenderness over rotator cuff, biceps tendon, AC joint of bilateral shoulders, lateral gutter and medial shoulder of both ankles and plantar medial aspect of both feet in the origin of the plantar fascia which extends into the medial arch. Limited cervical spine, bilateral wrists, bilateral hands, bilateral ankles and bilateral feet ROM secondary to pain was noted. Impingement sign was positive at the shoulders. Tinel's sign was positive at the wrists. EMG/NCV study of bilateral upper extremities dated 12/20/2013 revealed slowing of conduction of the median nerve across the wrists bilaterally. EMG/NCV study of bilateral lower extremities dated 05/18/2012 was unremarkable. MRI of the left knee dated 10/13/2004 revealed mild medial compartment joint space narrowing and early degenerative changes. X-ray of the left knee dated 10/13/2004 revealed mild medial compartment narrowing. X-ray of bilateral hands was unremarkable. MRI of the right shoulder dated 05/18/2005 revealed mild bicipital tenosynovitis. MRI of the cervical spine dated 04/18/2006 revealed straightening of cervical curve. MRI of the thoracic spine dated 07/22/2011 revealed mild facet joint arthropathy and mild foraminal narrowing extending from T10-T12 levels and mild degenerative endplate changes along the right anterolateral aspect of the vertebra. MRI of the lumbar spine dated 12/09/2011 revealed L2-3, L3-4, L4-5, and L5-S1 disc bulge. Treatment to date has included impingement release and labral repair of right shoulder (2011), medial and lateral meniscectomy, left knee

(2009), corticosteroid injections to bilateral shoulders, physical therapy, hot and cold wrap, TENS, knee brace, neck pillow, forearm crutches, thumb spica splint, knee braces, and pain medications. Utilization review dated 04/07/2014 denied the request for motorized scooter because there was no documentation that the patient was unable to walk.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Wheelchair Motorized:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices 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, physical examination findings of the upper extremity did not reveal weakness of the upper extremities. The guidelines do not recommend PMDs if functional mobility deficit can be resolved by a patient who has sufficient strength to propel a manual wheelchair. There is no discussion as to why an electric wheelchair is needed. The medical necessity has not been established. Therefore, the request for Wheelchair Motorized is not medically necessary.