MAXIMUS Federal Services

| Case Number: | CM14-0060610 | | |
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| Date Assigned: | 07/09/2014 | Date of Injury: | 02/21/2011 |
| Decision Date: | 09/08/2014 | UR Denial Date: | 04/21/2014 |
| Priority: | Standard | Application Received: | 05/01/2014 |

## 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 40-year-old male, who has submitted a claim for thoracolumbar and lumbosacral sprain associated with an industrial injury date of February 21, 2011.Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of upper back & neck pain, upper back & neck tightness, burning shoulder blade pain, low back and left leg pain. Physical examination of the dorsal lumbar spine showed bilateral iliolumbar and thoracic spinous tenderness. ROM (range of motion) was limited in flexion to 70 degrees; extension was limited to 20 degrees with pain on lateral extension. Straight leg raise caused pain in the seated position bilaterally.Treatment to date has included medications, trigger point injections and massage therapy.Utilization review from April 21, 2014 denied the request for purchase of motorized wheelchair because a manual wheelchair can be used instead.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**1 PURCHASE OF MOTORIZED 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 132.

**Decision rationale:** As stated on page 132 of CA MTUS Chronic Pain Medical Treatment Guidelines, it states that power mobility devices 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. In this case, documents reviewed showed that the patient does not have upper extremity function deficit. Progress note dated March 19, 2014 showed that the patient can lift very light objects, walk very short distances and is able tolerate walking as much as 30 minutes at a time. There is no sufficient data to demonstrate that the patient cannot tolerate a manual wheelchair or a cane. Therefore, the request for 1 purchase of motorized wheelchair is not medically necessary.