

Case Number:	CM14-0064154		
Date Assigned:	07/11/2014	Date of Injury:	07/11/2002
Decision Date:	09/03/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	05/07/2014

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 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 49-year-old female who has submitted a claim for lumbar and cervical discogenic degeneration, lumbar nerve root injury, obesity and arthritis associated with an industrial injury date of July 11, 2002. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of neck pain, back pain, bilateral leg pain and weakness. Physical examination revealed low back muscle spasm. Right shoulder abduction was limited to 30 degrees. Swelling in the feet, right arm and hand were noted. Bilateral handgrip weakness was noted. MRI of the lumbar spine dated 9/20/13 revealed the following findings: minimal effacement of anterior thecal sac at T12-L1; mild left neuroforaminal narrowing at L3-L4; moderate bilateral neuroforaminal narrowing and left-sided laminectomy at L4-L5; right-sided laminectomy and moderate bilateral neural foraminal narrowing at L5-S1; no nerve impingement; no fracture or malalignment; and no significant posterior disc pathology. Treatment to date has included a neck brace, a motorized wheelchair, a non-motorized wheelchair, and medications, which include OxyContin, Norco, Elavil, Neurontin, Nexium, Seroquel, Oxycodone, Pantoprazole, Morphine, Benadryl, Valium, Celexa, Lidoderm patch, Lyrica, Keflex, Locoid cream and Neosporin cream. Utilization review from April 10, 2014 denied the request for 1 motorized wheelchair between 4/8/2014 and 5/23/2014 because clarification is needed regarding the request (motorized or non-motorized) since the record reviewed did not indicate that the patient's current motorized wheelchair is non-functional to warrant replacement. Moreover, in the sole clinical report dated 3/26/14, there was no mention of a plan to request for a motorized unit. Instead, the requesting provider stated " she needs the non-motorized wheelchair permanently for home use because her motorized wheelchair is too large to use daily in the house."

IMR ISSUES, DECISIONS AND RATIONALES

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

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 Guidelinesknee and leg, durable medical equipment, power mobility devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99, 132.

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 wheelchair since at least 2012. Physical findings reveal significant upper extremity weakness. The patient also has severe back pain and bilateral leg pain and weakness. She uses the motorized wheelchair to assist her in doing her activities of daily living. Progress note dated 9/16/13 mentioned that the patient needs a small lightweight non-motorized wheelchair for use at home to get around the house because her motorized wheelchair was too large. According to the report, the non-motorized wheelchair was authorized twice and delivered per 3/8/13 Mr. Murphy letter. The patient also has a caregiver to assist him. Review of records indicates that the patient had repair of wheelchair battery and battery charger done on 9/4/12. While the need for a wheelchair may be necessary given the patient's extensive disability, clarification is needed as review of records indicates that the patient currently has both a motorized wheelchair and a non-motorized wheelchair. There was no mention that the motorized wheelchair was non-functional. It is unclear as to why another motorized wheelchair is needed at this time. Therefore, the request for Motorized wheelchair is not medically necessary.