

Case Number:	CM14-0086450		
Date Assigned:	07/23/2014	Date of Injury:	06/10/1998
Decision Date:	08/28/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/09/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 61 year-old female with a reported date of injury on 06/10/1998. The mechanism of injury was not provided within the medical records. The injured worker has a diagnosis of complex regional pain syndrome. There was no documentation of previous treatments provided. The injured worker had an examination on 02/13/2014, where she complained of pain to her wrist. The injured worker utilized a walker to ambulate which was an additional source of pain. The injured worker was utilizing oxygen at 3 liters per minute and she needed assistance to pick up her medications. The medication list consists of MS Contin along with morphine sulfate. There was no treatment plan provided and there was no request or authorization form for a Hoveround powered wheelchair, nor was the rationale provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hoveround power 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): 99.

Decision rationale: The MTUS guidelines do not recommend a power mobility device if a functional mobility deficit can be sufficiently resolved by the prescription of a cane or a walker or if the injured worker has sufficient upper extremity function to propel a manual wheelchair. The requesting physician did not provide a complete physical examination of the injured worker. There is no evidence of functional limitation or deficits. It was indicated that the injured worker has previously walked with a walker which caused the pain in her right wrist to increase. There is no evidence indicating the walker the injured worker is using is inadequate in assisting with ambulation. There is no indication that the injured worker has tried a manual wheelchair or that she lacks the strength to propel a manual wheelchair. There is a lack of documentation demonstrating significant ambulatory deficits for which a power mobility device would be indicated. Therefore, the request for a Hoveround powered wheelchair is not medically necessary.