

Case Number:	CM14-0084187		
Date Assigned:	07/25/2014	Date of Injury:	02/19/2008
Decision Date:	01/02/2015	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/05/2014

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with February 19, 2008. In a Utilization Review Report dated May 27, 2014, the claims administrator denied a request for an electric wheelchair. The claims administrator did allude to the applicant's having undergone open reduction and internal fixation of a right Lisfranc fracture and further alluded the applicant having sustained a left medial malleolar fracture and left talar dome fracture some six years prior. The claims administrator stated that its decision was based on May 22, 2014 Request for Authorization (RFA) form and progress notes of May 8, 2014 and March 11, 2014. The applicant attorney subsequently appealed. In a progress note dated March 11, 2014, the applicant reported ongoing complaints of low back, mid back and bilateral lower extremity pain, aggravated by standing, walking, bending, turning, and twisting. 4 to 8/10 pain was appreciated. The applicant exhibited multiple palpable tender points on exam. The applicant was given diagnoses of chronic low back pain, lumbar radiculitis, lumbar radiculopathy, status post spinal cord spinal cord stimulator implantation, complex regional pain syndrome of the right lower extremity, and bilateral ankle pain. The applicant was placed off of work, on total temporary disability, and received prescription with Neurontin, Lidoderm, Naprosyn, Tizanidine, and Tylenol No. 4. On June 5, 2014, the applicant reported 2/10 pain with medications and 8/10 pain without medications. Primary complaints of low back pain radiating to the bilateral lower extremities was appreciated. Somewhat limited lumbar and thoracic spine range of motion were appreciated. The applicant was placed off of work, on total temporary disability. The applicant's gait was not described. Authorization was sought for an electric scooter owing to the applicant's reported difficulty with ambulation. The attending provider stated that the applicant's spinal cord stimulator was not functional. The attending provider stated that the applicant needed an electric wheelchair on the

grounds that the applicant did not have a caregiver on home who could push his wheelchair about.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric Wheelchair: 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: As noted on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines, power mobility devices such as the electric wheelchair at issue are not recommended if an applicant's functional mobility deficits can be sufficiently resolved through a cane, walker, or manual wheelchair. Motorized scooters are not essential to care, page 99 of the MTUS Chronic Pain Medical Treatment Guidelines goes on to note, and further states that exercise and mobility are encouraged at all stages of the injury process. In this case, the applicant's gait has not been clearly described or characterized on several progress notes, referenced above. It is clear why the applicant cannot ambulate of his own accord, despite ongoing complaints of low back and/or lower extremity pain. The attending provider has not elaborated, expounded upon, or described or characterized the extent of the applicant's mobility deficits (if any) nor the attending provider outlined a compelling case for provision of the electric wheelchair at issue. Therefore, the request is not medically necessary.