

Case Number:	CM15-0022654		
Date Assigned:	02/12/2015	Date of Injury:	11/16/2004
Decision Date:	04/03/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 56-year-old female who reported an injury on 11/16/2004 due to an unspecified mechanism of injury. On 12/09/2014, she presented for a followup evaluation regarding her lumbar spine discomfort and bilateral knee discomfort. She rated her pain in the lumbar spine and bilateral knees at 10/10 and also reported increased paresthesias into the lower extremities and reported falling on a regular basis. A physical examination showed a moderately antalgic gait due to low back pain as she ambulated with the assistance of a cane. There was decreased sensation to the lower right extremity in the L5 dermatome in the top of the foot. There was moderate spasm of the paralumbar muscles and range of motion was documented as flexion 60% of normal, extension 40% of normal, right lateral flexion 60% of normal, and left lateral flexion 80% of normal. Straight leg raise was positive on the right and left. Inspection of the right knee showed slight swelling with tenderness of the medial joint line and patellar region. Extension was 0 degrees and flexion was 120 degrees/40 degrees. She was diagnosed with lumbar radiculopathy right greater than left, secondary depression, insomnia, GI upset, right knee pain, and status post motor vehicle accident. The treatment plan was for a replacement wheelchair for the low back. The rationale for treatment was not stated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement wheelchair, lower back: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Wheelchair.

Decision rationale: The Official Disability Guidelines recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. The request for a "replacement wheelchair" indicates that the injured worker is already utilizing a wheelchair. However, there is a lack of documentation indicating that the injured worker's wheelchair is not providing her with the ability to move around in her residence or that the wheelchair is not working or broken. Without a clear rationale for the medical necessity of a replacement wheelchair, the request would not be supported. Therefore, the request is not medically necessary.