

Case Number:	CM15-0222979		
Date Assigned:	11/19/2015	Date of Injury:	09/25/1998
Decision Date:	12/30/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	11/13/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 66 year old female with a date of injury of September 25, 1998. A review of the medical records indicates that the injured worker is undergoing treatment for chronic pain, lower back pain, muscle weakness, myalgia, lumbosacral intervertebral disc disorder, and post- laminectomy syndrome. Medical records dated August 19, 2015 indicate that the injured worker complained of severe back pain radiating to the bilateral lower extremities with numbness rated at a level of 10 out of 10 and 7 out of 10 with medications. A progress note dated October 14, 2015 documented complaints similar to those reported on August 19, 2015 with pain rated at a level of 8 out of 10 with medications. Records also indicate that the injured worker was "Not stable and has a history of falling", and that she was prescribed a wheeled walker but was unable to use it properly because of arm weakness and pain. Per the treating physician (October 14, 2015), the employee was permanent and stationary and was not working. The physical exam dated August 19, 2015 reveals atrophy and weakness, a heel walk gait, tenderness of the thoracic spine, severe pain with range of motion of the thoracic spine, tenderness of the lumbar spine, severe pain with range of motion of the lumbar spine, severe pain with range of motion of the left ankle, hypoesthesia in the L4 distribution bilaterally, and decreased deep tendon reflexes. The progress note dated October 14, 2015 documented a physical examination that showed a limping, unstable gait, tenderness of the thoracic

spine, severe pain with range of motion of the thoracic spine, tenderness of the lumbar spine, severe pain with range of motion of the lumbar spine, and bilateral hypoesthesia more pronounced in the anterior aspect of the lower limbs. Treatment has included medications (Ibuprofen, Kadian, Norco, and Skelaxin) and lumbar spine surgery. The utilization review (October 22, 2015) non-certified a request for a wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wheelchair, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic) - Wheelchair.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use; i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The equipment itself is not rentable or able to be used by successive patients. It does not serve a primary medical purpose that cannot be accomplished without it. The patient does not have documented upper extremity weaknesses with objective measures that prevent other means of ambulatory assistance. Therefore criteria have not been met per the ODG and the request is not medically necessary.