

Case Number:	CM14-0128628		
Date Assigned:	08/20/2014	Date of Injury:	02/03/1984
Decision Date:	10/06/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/13/2014

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 Nevada. 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 65 year-old male who was reportedly injured on 2/3/1984. The mechanism of injury is noted as a slip and fall. The most recent progress note dated 5/20/2014, indicates that there are ongoing complaints of chronic low back pain that radiates into the left lower extremity. The physical examination demonstrated: injured worker uses a wheelchair, is friendly, is able to stand and walk within the examination. The injured worker exhibits a left thoracolumbar scoliosis. The cervical spine bilateral paracervical regions are tender to touch, as well as the right trapezius. Positive tenderness to palpation at the posterior glenohumeral and rhomboid area of the schedule thoracic region. Limited bilateral shoulder range of motion. Patient is unable to heel and toe walk bilaterally. Bilateral lower extremity reflexes 1+. No recent diagnostic studies are available for review. Previous treatment includes lumbar fusion, medications and conservative treatment. A request was made for motorized scooter and was not certified in the pre-authorization process on 7/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT MI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
POWER MOBILITY DEVICES Page(s): 78 AND 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg (Acute and Chronic). Power Mobility Devices. Updated 8/25/2014.

Decision rationale: Power Mobility Devices such as motorized wheelchairs 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 and willing to provide assistance with a manual wheelchair. After review the medical records provided it is noted the patient does use a manual wheelchair, is able to stand and walk in an exam room. He has no significant deficit of his upper extremities that would prevent him from operating a manual wheelchair. Therefore according to Official Disability Guidelines guidelines this request is deemed not medically necessary.