

<b>Case Number:</b>	CM14-0133555		
<b>Date Assigned:</b>	08/27/2014	<b>Date of Injury:</b>	12/05/2011
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	08/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2014

### 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:

According to the records made available for review, this is a 53-year-old female with a 12/5/11 date of injury. At the time (7/21/14) of request for authorization for motorized Wheel Chair (rental or purchase), there is documentation of subjective (chronic left upper extremity pain and epigastric discomfort) and objective (tender epigastric area; left arm in chronic flexion and left hand in claw-like flexion) findings, current diagnoses (complex regional pain syndrome of left upper extremity, chronic pain, gastroesophageal reflux disease, and neurogenic bladder), and treatment to date (medications and physical therapy). There is no documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized Wheel Chair (rental or purchase):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES Page(s): 132.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair, as criteria necessary to support the medical necessity of Motorized Wheelchair or Scooter. Within the medical information available for review, there is documentation of diagnoses of complex regional pain syndrome of left upper extremity, chronic pain, gastroesophageal reflux disease, and neurogenic bladder. However, there is no documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair. Therefore, based on guidelines and a review of the evidence, the request for motorized Wheel Chair (rental or purchase) is not medically necessary.