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| Case Number: | CM14-0142886 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 09/29/2011 |
| Decision Date: | 10/30/2014 | UR Denial Date: | 07/31/2014 |
| Priority: | Standard | Application Received: | 09/03/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and 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 30 year old male whose date of injury is 09/29/2011. The mechanism of injury is described as a right foot crush injury when a forklift rolled over the foot. Progress report dated 03/27/14 indicates that the injured worker complains of low back, right foot and left foot pain. The injured worker started physical therapy for the right lower extremity. He also received a wheelchair rental. Diagnoses are chronic pain syndrome, crushing injury of foot, and trauma-arthropathy ankle/foot. Note dated 07/10/14 indicates that there is a large bulky muscle graft that covers the majority of the foot. The graft extends to the dorsal aspect to the base of the toes. Supplemental report dated 07/16/14 indicates that the injured worker is status post multiple surgeries.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric Wheel Chair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES (PMDs) Page(s): 99.

Decision rationale: Based on the clinical information provided, the request for electric wheelchair is not recommended as medically necessary. CA MTUS guidelines note that power mobility devices 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, willing, and able to provide assistance with a manual wheelchair. The submitted records indicate that the injured worker has been provided a wheelchair. There is no indication that the injured worker lacks sufficient upper extremity function to propel a manual wheelchair. There is no clear rationale provided to support the request at this time.