

<b>Case Number:</b>	CM14-0145484		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	12/10/2008
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Family Practice and is licensed to practice in Texas. 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 36 year old female who reported an injury on 12/10/2008. The mechanism of injury was not specified. Her diagnoses included lumbar disc herniation/injury with radiculopathy, status post lumbar spine surgery with severe pain, possible painful hardware, myofascitis, sacroiliitis, situational reactive depression/anxiety, severe cervicogenic headaches, and inability to perform activities of daily living. Her treatments included several intramuscular injections for pain and biofeedback. She had a lumbar CT done twice. She had lumbar spine surgery on an unknown date. On 05/21/2014 the injured worker reported escalating symptoms in her low back and legs and cervicogenic headaches on a daily basis. The physical examination of the lumbar spine revealed guarding with range of motion, increased muscle spasm, and 15 degrees of lateral motion bilaterally. Her medications included Cymbalta, Klonopin, Topamax, Robaxin, Phenergan, Demerol, Exalgo, Dilaudid, Prilosec, Lidoderm patches, and Subsys. The treatment plan was for Wheelchair. The rationale for request and the request for authorization form were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Wheelchair:** 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 Procedure Summary

**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, Wheelchair

**Decision rationale:** As stated in the Official Disability Guidelines, a manual wheelchair is recommended if it is required and if it will be used by the patient to move around in their residence. The injured worker reported escalating symptoms in her low back and legs and cervicogenic headaches on a daily basis. Her previous treatments were noted as several injections during a physician office visit and biofeedback. The guidelines indicate that a wheelchair is recommended if it will be used by the patient to move around in his/her residence; however, there was a lack of details stating that the wheelchair is required by the patient or that she is in need of a wheel chair to move around her residence. There is a lack of documentation which indicates the injured worker has significant objective functional deficits which are not alleviated with the use of a cane or walker. The requesting physician's rationale for the request is not indicated within the provided documentation. As such, the request for a wheelchair is not medically necessary.