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| Case Number: | CM14-0026812 | | |
| Date Assigned: | 03/05/2014 | Date of Injury: | 07/14/2010 |
| Decision Date: | 04/15/2014 | UR Denial Date: | 02/20/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine 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:

This patient is a 63 year-old male with a date of injury of 07/14/2013. The listed diagnoses dated 02/06/2014 are: 1) Cervical spine strain/sprain with radiating pain down shoulders. 2) Lumbar spine 2-3 mm disc bulges at L3-S1. 3) Left elbow strain, lateral epicondylitis. 4) Thoracic spine injury. 5) Right foot contusion. 6) Minimally displaced right patellar fracture of the right knee and status post arthroscopy on 05/07/2011. 7) Rib cage abnormal contusion. According to report dated 02/14/2014, the patient presents with continued weakness, numbness and heaviness to the legs. He indicates he has fallen twice since last visit and feels his legs do not support him. He continues to have lower extremity pain that starts in the mid back area and shoots down his buttocks to his lower extremities. Examination reveals right quad atrophy and weakness. He has full extension of right leg with 120 degrees flexion and positive straight leg raise test.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRIC WHEELCHAIR FOR USE OUTSIDE OF HOME: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (Pmd) Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Decision rationale: This patient presents with continued weakness, numbness and heaviness to the legs. The treater is requesting an electric wheel chair for "use when he leaves the house for support as he has difficulty doing any prolonged walking due to lower extremity weakness." For Power Mobility Devices, the MTUS guidelines pg 99 has the following: ""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. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." In this case, the treater has concerns of the patient's instability due to lower extremity weakness. However, it is not made clear as to why this patient is unable to utilize a walker or cane for support. Furthermore, the patient's upper extremity appears to have no issues giving consideration for a manual wheelchair if needed. Recommendation is for denial.