

Case Number:	CM14-0150351		
Date Assigned:	09/18/2014	Date of Injury:	10/02/2003
Decision Date:	01/02/2015	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/15/2014

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 Internal 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:

The patient is an injured worker with a history of surgical interventions of the lumbar spine. Date of injury was 10-20-2003. The patient had surgical interventions of the lumbar spine including left L4-5 microdiscectomy in 2011 followed by L4-5 and L5-S1 laminotomy discectomy in December 2011. The pain management consultation report dated July 15, 2014 documented subjective complaints of right shoulder, neck, lower back pain, and radicular symptoms to both lower extremities. The patient has been evaluated by an orthopedic spine surgeon, who did not see any obvious instability and is not recommending further surgical intervention at this time. Medications included Oxycontin, Norco 10/325 mg, Prilosec, Anaprox, and Valium. Objective findings were documented. The patient is found to be alert and cooperative. The patient requires the aid of a walker. She is accompanied by her husband. Upper extremity motor testing demonstrated normal 5/5 strength in bilateral shoulder abductors, elbow flexors, elbow extensors, wrist flexors, and wrist extensors. Deep tendon reflexes were 2+ in the biceps, triceps, and brachioradialis bilaterally. Lumbar spine range of motion demonstrated flexion 45 degrees, extension 15 degrees, and lateral bending 20 degrees. Deep tendon reflexes were 2+ in the patella and 1+ in the Achilles bilaterally. Lower extremity motor testing demonstrated normal 5/5 strength with knee flexion and knee extension bilaterally. Motor strength was 4+/5 with ankle flexion, ankle extension, and great toe extension bilaterally. Diagnoses included lumbar post-laminectomy syndrome with bilateral lower extremity radiculopathy, status post left L4-5 microdiscectomy October 2011, status post L4-5 and L5-S1 laminotomy discectomy December 2011, cervical myoligamentous injury, bilateral carpal tunnel syndrome, and right rotator cuff tear. A wheelchair lift for motorized wheelchair was requested. Utilization review determination date was 8/26/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Wheelchair lift for motorized wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMD) Page(s): 99.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines states 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. If there is any mobility with canes or other assistive devices, a power mobility device is not essential to care. The pain management consultation report dated July 15, 2014 documented that the patient was able to ambulate with the aid of a walker. The patient was alert and cooperative. She was accompanied by her husband. Upper extremity motor testing demonstrated normal 5/5 strength in bilateral upper extremities. Lower extremity motor testing demonstrated normal 5/5 strength with knee flexion and knee extension bilaterally. Motor strength was 4+/5 with ankle flexion, ankle extension, and great toe extension bilaterally. Medical records document mobility with a walker, normal upper extremity strength, and the availability of a caregiver. Lower extremity strength was 5/5 and 4+/5. Therefore, a motorized wheelchair and wheelchair lift is not supported by MTUS guidelines. Therefore, the request for Wheelchair lift for motorized wheelchair is not medically necessary.