

Case Number:	CM14-0217267		
Date Assigned:	01/07/2015	Date of Injury:	04/05/2004
Decision Date:	03/05/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 74 year old male who sustained a work related injury on April 5, 2004 while working as a heavy duty mechanic. The mechanism of injury was a fall from an eight foot high rack to the ground. The injured worker sustained injuries to his bilateral shoulders mid back, low back and left knee. The injured worker underwent a left knee medical and lateral meniscectomy in 2004, followed by post-preoperative physical therapy. A physicians report dated May 12, 2014 notes that the injured worker presented with upper back pain rated at a one out of ten, low back pain rated at a five out of ten, left knee pain rated at a three to four out of ten and bilateral shoulder pain rated at a two to three out of ten on the subjective pain scale. Current documentation dated November 10, 2014 notes the injured worker reported quite a bit of low back and left knee pain and was having difficulty with activities of daily living. He was requesting a motorized wheelchair. Physical examination of the cervical spine revealed decreased range of motion and tenderness in the paraspinal muscle. No guarding or spasms were noted. Bilateral shoulder examination showed tenderness anteriorly and laterally with decreased range of motion. Lumbar spine examination showed tenderness to the paraspinal muscle and decreased range of motion. Straight leg raise and FABER test were negative. Thoracic spine examination showed tenderness over the paraspinal muscle with no spasms or guarding. The left knee examination revealed a negative anterior drawer sign. McMurray's sign and a valgus and varus stress test were negative. Tenderness was noted in the joint line. Muscle strength of the shoulders and lower extremities were normal. The injured workers pain levels were not noted. Diagnoses include chronic thoracic sprain/strain, chronic lumbar sprain/strain, chronic low back

pain with disk disease, bilateral shoulder sprain/strain, worse on the right and status post left knee medical and lateral meniscetomy with chronic pain. Work status is permanent and stationary. The treating physician requested a motorized wheelchair. Utilization Review evaluated and denied the request on December 11, 2014. Per Utilization Review there is lack of documentation that the injured worker had gait issues or the need for assistive devices. In addition, there is no indication the injured worker did not have sufficient upper body function to propel a manual wheelchair or that there was not a caregiver available to provide assistance with a manual wheelchair. Based on the CA MTUS Chronic Pain Medical Treatment Guidelines the medical necessity of the request was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & Leg (Acute & Chronic chapter, Power mobility devices (PMDs))

Decision rationale: The patient presents with neck, shoulder, and lumbar spine pain. The request is for MOTORIZED WHEELCHAIR. Patient is status-post left knee medial and lateral meniscectomy -unspecified date-with chronic pain. Physical examination revealed motor strength 5/5 in the shoulders and 5/5 in the lower extremities. Per Supplemental Report with Review of Record document dated 06/17/14, in regards to the left shoulder, patient has 6% impairment of the upper extremities which is 4% WPI, right shoulder has 8% impairment, and the left knee has 12% WPI. Patient's medications include Tramadol. Patient's diagnosis included chronic thoracic S/S, chronic lumbar S/S, chronic low back pain with disk disease and -B/L R> L shoulder S/S. Patient is on home exercise program and is permanent and stationary. ODG guidelines, chapter 'Knee & Leg (Acute & Chronic)' and topic 'Power mobility devices (PMDs)', states, "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." Per progress report dated 11/10/14, the treater states that the patient is having knee and low back pain and has difficulty getting around. In this case, patient is on home exercise program and there is no evidence of gait issue or need for assistive devices. There is also no indication that the patient does not have sufficient upper extremity function to propel a manual wheelchair or that there is not a willing care giver available. More importantly, the patient has normal motor strength in both of the lower extremities. Therefore, the request is not medically necessary.