

<b>Case Number:</b>	CM15-0118225		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	09/24/1997
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 65-year-old male, who sustained an industrial/work injury on 9/24/97. He reported initial complaints of back spasm and pain. The injured worker was diagnosed as having carpal tunnel syndrome, back disorders, adjustment reaction with prolonged depressive reaction, urinary incontinence, and spinal stenosis of the lumbar region without neurogenic claudication. Treatment to date has included medication and transcutaneous electrical nerve stimulation (TENS) unit. Currently, the injured worker complains of more spasm in the back and legs at night due to increased pain. There is shorter duration for sitting, standing, or walking before needing to lie down. There is more difficulty with walking a distance. A cane is used for ambulation and a walker is used for severe pain. Per the primary physician's progress report (PR-2) on 6/2/15, examination noted antalgic gait, with frequent position changes, and depression. There is pain in the neck, right arm, lower back, down both legs, left elbow, rated pain as 7- 7.5/10, and bouts of incontinence. The requested treatments include motorized wheelchair for purchase, lumbar spine and bilateral wrists.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized wheelchair for purchase, lumbar spine & bilateral wrists: Upheld**

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

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

**Decision rationale:** According to the guidelines, powered 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. In this case, the claimant was able to use a cane and had 70% pain relief with medications. The request for a motorized wheelchair does not meet the guidelines specifications. As a result, the request above is not medically necessary.