

Case Number:	CM15-0031717		
Date Assigned:	02/25/2015	Date of Injury:	05/12/2006
Decision Date:	05/29/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	02/19/2015

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: 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:

The injured worker is a 46-year-old female, who sustained an industrial injury on 05/12/2006. The initial complaints or symptoms included sudden onset of back pain while bathing a patient. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, injections, conservative therapies, oral surgery, x-rays and MRIs. Currently, the injured worker complains of constant sharp pain to the low back thoracic spine, neck and bilateral arms and wrist with numbness, tingling, and muscle spasms. It was reported that the injured worker depended on the assistance of others for activities of daily living and was unable to propel herself in her wheelchair with her arms requiring the use of her feet. The diagnoses include displacement of cervical intervertebral disc without myelopathy, opioid dependence, lumbosacral spondylosis without myelopathy, degeneration of cervical intervertebral disc, and pathologic fracture of vertebrae. The treatment plan consisted of purchase of electric powered wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric power wheelchair: 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 Power mobility devices (PMDs) Page(s): 99.

Decision rationale: The patient presents on 12/08/14 with lower back, thoracic spine, neck, and bilateral upper extremity pain rated 7/10. The patient's date of injury is 05/12/06. Patient has no documented surgical history directed at these complaints. The request is for electric power wheelchair. The RFA was not provided. Physical examination dated 12/08/14 reveals that the patient presents in a self-propelled wheelchair, with increasing difficulty secondary to pain. The physical examination does not include any positive physical findings. The review of systems finds no deficits aside from the inability to stand, and no examination of the lower extremities is included. Bilateral upper extremity examination does not include any disturbances in range of motion, neurological function, or grip strength. The patient is currently prescribed Flector patches, Relpax, Novolog, Lantus, Dilaudid, Duragesic, Soma, Abilify, Cymbalta, Lyrica, Oxybutynin, and Klonopin. Diagnostic imaging was not included. Patient's current work status is not provided. MTUS Chronic Pain Medical Treatment Guidelines, page 99, under "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." In regard to the request for an electric power wheelchair, the patient does not meet guideline criteria. Progress note dated 12/08/14 reveals that this patient is requesting an electric power wheelchair, as she is "unable to propel herself with her arms, pushes with right foot." However, the same progress note does not document any abnormal neurological findings, loss of strength, or other functional deficit to the upper extremities. There is no discussion of a lack of caregiver assistance, either. MTUS does not support the issuance of motorized wheelchairs in patient's with sufficient upper extremity function to propel a standard wheelchair. Without demonstrated upper extremity deficit or discussion as to why this patient does not receive caregiver assistance, the requested motorized wheelchair cannot be substantiated. The request is not medically necessary.