

Case Number:	CM15-0068709		
Date Assigned:	04/16/2015	Date of Injury:	03/04/1993
Decision Date:	05/15/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/10/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 74 year old female, who sustained an industrial injury on March 4, 1993. Treatment to date has included intrathecal therapy, medications, assistive device and previous back surgery. Currently, the injured worker complains of right lower extremity pain. She rates her pain a 6 on a 10-point scale. Diagnoses associated with the request included right lower extremity neuropathic pain and failed back surgery syndrome. Her treatment plan includes refill/reprogram of intrathecal pump and mobility device for increased activity opportunity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Mobility Device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Powered Mobility Devices.

Decision rationale: The chronic pain guidelines state the following regarding motorized wheel chairs: "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." Additionally, ODG comments on motorized wheelchairs and says 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. (CMS, 2006) 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." From the medical notes, it is clear that she is able to use a cane or a walker and ambulate. She can sit and stand for 30 minutes. There is no medical documentation that the patient does not have sufficient upper extremity strength to propel a manual wheelchair or that there is no caregiver available. Therefore, the request for a motorized wheelchair is not medically necessary.