

Case Number:	CM15-0069841		
Date Assigned:	04/17/2015	Date of Injury:	05/29/2008
Decision Date:	05/18/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/13/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 55 year old male, who sustained an industrial/work injury on 5/29/08. He reported initial complaints of bilateral hip pain. The injured worker was diagnosed as having osteoarthritis of hips. Treatment to date has included medication, diagnostics, surgery (left hip arthroscopy with labral debridement, femoral neck osteoplasty, and acetabuloplasty on 11/29/10). Electromyography and nerve conduction velocity test (EMG/NCV) was performed on 12/27/12. X-Rays results were reported on 8/9/12, 11/6/12. Bone scan was performed on 4/16/14. Currently, the injured worker complains of hip pain with prolonged ambulation. Per the primary physician's progress report (PR-2) on 2/20/15, the injured worker had anterior hip pain with ambulation, s/p total hip arthroplasty. Discussion on femoral stem revision per bone scan was discussed. The requested treatments include wheelchair (indefinite use).

IMR ISSUES, DECISIONS AND RATIONALES

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

Wheelchair (Indefinite Use): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelchair. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Wheelchair “recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair. (CMS, 2007) For powered wheelchairs, see Power mobility devices (PMDs).” The patient developed unspecific mechanical complication of internal orthopedic device that may require a wheelchair for mobilization. However there no clear justification for the indefinite without periodic documentation of the patient needs. Therefore, the request is not medically necessary.