

Case Number:	CM15-0079680		
Date Assigned:	04/30/2015	Date of Injury:	04/15/2005
Decision Date:	06/01/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/27/2015

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 64-year-old male, who sustained an industrial injury on 4/15/05. He reported back pain radiating to the lower extremities. The injured worker was diagnosed as having lumbar spine sprain/strain and right shoulder strain. Treatment to date has included lumbar laminectomy at L1-2, posterior spinal fusion at L1-2, and L4-S1 lumbar laminectomy and decompression. Other treatment included physical therapy, and occupational therapy. Currently, the injured worker complains of low back pain with lower extremity weakness, neurogenic claudication, urinary incontinence and occasional bowel loss. The treating physician requested authorization for a lightweight 18" wheelchair with a 2" foam cushion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lightweight 18" Wheelchair with 2" Foam Cushion for Wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Knee & Leg (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Mobility Devices Page(s): 100.

Decision rationale: The patient was authorized for a standard wheelchair for post-operative use on 3/25/15. There is no report of neurological limitations or clinical findings involving upper extremity to support for a lightweight wheelchair. The patient has sufficient upper extremity function to propel a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and there is any mobility with canes or other assistive devices, as appropriate. The patient remains ambulatory and does not appear to be homebound. The criterion for the lightweight wheelchair has not been met from the submitted reports. There are no documented clinical motor or neurological deficits of the upper extremities to contradict the use of the standard wheelchair authorized. Therefore, the request is not medically necessary and appropriate.