

<b>Case Number:</b>	CM13-0070231		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	05/31/2001
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 60 year old female who reported an injury on 05/31/2001 of an unknown mechanism. The injured worker complained of low back, bilateral knees, and left shoulder pain as well as gastrointestinal upset from pain medications and depression. The clinical note dated 10/15/2013 showed the injured worker to have right knee tenderness with right and left flexion of 90 degrees, lumbar tenderness, range of motion 60% of normal to lumbar spine, negative impingement sign of both shoulders with right flexion of 115 degrees and abduction of 140 degrees. A lumbar MRI (magnetic resonance imaging) on 09/06/2013 revealed degenerative bone, disc and joint changes throughout the lumbar spine with anterolateral osteophytes seen involving the lower thoracic spine as well as associated mild spinal stenosis at the L2 through S1 levels, and moderate narrowing of the L3, L4, and L5 neural foramina bilaterally. She had diagnoses of right knee and left knee strain compensable consequence due to right knee strain, lumbar strain with right lumbar radiculitis, secondary depression and insomnia due to chronic pain, gastroesophageal reflux due to pain medications and a fall in 10/2012 with recovery not as expected. Per documentation, her past treatments were only with oral medication and there was a request for a heating pad. She was taking ibuprofen, Vicodin, Soma, Cidaflex, using Lidoderm patch, Voltaren gel and an authorization was requested for omeprazole for GI upset. The treatment plan is for a rear hydraulic van ramp. The request for authorization form was signed and dated 07/25/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REAR HYDRAULIC VAN RAMP:** 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 (PMDs) Page(s): 99.

**Decision rationale:** The injured worker complained of low back, bilateral knee, left shoulder pain and gastrointestinal upset from pain medications as well as depression. Her past treatments per documentation were oral medication and there was a request for a heating pad. The MTUS Chronic Pain Guidelines states power mobility devices (PMDs) are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or if 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. The documentation does not state any deficits to the upper extremities nor the inability to ambulate with cane or walker. As such, the request is not medically necessary and appropriate.