

<b>Case Number:</b>	CM14-0177850		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	03/18/1999
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker (IW) is a 51 year old male who sustained an industrial injury on 03/18/99. He has been diagnosed with severe cervical and lumbar degenerative disease, nocturnal seizures, and essential tremor. Per 09/12/14 office note, seizures are well controlled on Keppra. IW's wife reported witnessed apneas and loud snoring, but a recent polysomnogram showed no diffusion abnormalities. IW was using nocturnal O2 at 2 liters. He reported worsened tremor since discontinuing Propranolol due to bradycardia. Treating physician noted a history of multiple recent falls due to chronic pain and imbalance. IW was noted to use a manual wheelchair at home, and wanted an electric wheelchair because bilateral wrist tendinitis and chronic pain made it difficult for him to use his manual wheelchair. Review of systems was positive for chronic neck and low back pain and chronic dizziness. On exam, bruising of the lower extremities was noted. Cranial nerves 3-12 were normal. Strength was full in the upper and lower extremities and sensation was intact. Finger-to-nose testing was intact with intention tremor. Wide based and cautious gait was noted. A detailed musculoskeletal exam, including examination of the wrists, hands, neck, and back, was not documented. Imaging studies of the neck and back were not documented. Assessment was essential tremor, seizures, and lumbar degenerative disc disease. Treating physician stated that IW would benefit from an electric wheelchair due to severe lumbar and cervical degenerative disease. 09/29/14 home environment evaluation stated that IW's house was very open and was going through further remodeling to make it more open. The bathroom and master bedroom doors were being widened.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pride jazzy select 6 power wheelchair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Medicare Coverage of Power Operated Vehicles

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Official Disability Guidelines (ODG) Pain Chapter, Power Mobility Devices (PMDs).

**Decision rationale:** Concerning use of power mobility devices, ODG 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." Per office notes, IW has full strength in the upper extremities. Objective findings which would corroborate a degree of upper extremity dysfunction which would render IW unable to use a manual wheelchair or rolling walker are not documented in the physical exam. The availability of a caregiver who could assist as needed with use of a manual wheelchair is not addressed in the submitted documentation. Medical necessity is not established for the requested power wheelchair per ODG criteria.

**U-1 batteries x2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Medicare Coverage of Power Operated Vehicles

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Power Mobility Devices (PMDs)

**Decision rationale:** The requested batteries are for use with a power wheelchair. Because a power wheelchair is not certified, medical necessity is not established for the requested batteries.