

<b>Case Number:</b>	CM14-0068158		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	06/18/1998
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 63-year-old male who was reportedly injured on June 18, 1998. The mechanism of injury was noted as a fall. The most recent progress note dated June 30, 2014, indicated that there were ongoing complaints of low back pain. Current medications include Fentanyl, Actiq and methadone. The physical examination demonstrated minimal ambulation without the use of a wheelchair. There was no lumbar spine tenderness or spasms. Bilateral venous stasis was noted in both lower extremities. There was full muscle strength of the lower extremities and decreased sensation at the posterior lateral aspect of the left leg. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included multiple lumbar spine surgeries as well as acupuncture, physical therapy, and aqua therapy. A request was made for a Hoveround personal power mobility device and was not certified in the pre-authorization process on May 5, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hoveround Personal Power Mobility Device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs) Page(s): 99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Power Mobility Devices, updated June 5, 2014.

**Decision rationale:** According to the Official Disability Guidelines, the use of power mobility devices 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 if there is a caregiver who is available and willing and able to provide assistance with a manual wheelchair. According to the attached medical record, the injured employee was able to propel himself using a manual wheelchair and also lives with his wife and children who are able to assist him. Therefore, this request for a Hoveround personal power mobility device is not medically necessary.