

<b>Case Number:</b>	CM15-0183290		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	07/11/1993
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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, Hawaii

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:

This is a 74 year old male whose date of injury was July 11, 1993. The medical records (9-9-15) indicated the injured worker was treated for low back pain. He rated his back pain a 5 on a 10-point scale with some radiation of pain down the left lower extremity. He said his back pain worsens with walking and he can go 60 to 100 feet without sitting down and resting. He felt that his mobility was "down to zero." He has no significant problems with his upper extremities and said that one of the biggest problems is mobility when shopping. He cannot go down isles for very long before having to sit down. On physical examination, the injured worker can bend so that his fingertips are 12 to 15 inches above the floor. Side bending allows him to touch a point well above the lateral joint lines of each knee. He was able to rotate the shoulders 50 degrees bilaterally. He had tenderness to palpation across the mid lumbar region of the low back and straight leg raise was positive at 60 degrees bilaterally. Medications included amitriptyline which helped lessen the tingling in his feet. The injured worker was diagnosed as having lumbar spine degenerative disc disease. A request for authorization for a durable medical equipment powered mobility device was received on September 9, 2015. On September 16, 2015, the Utilization Review physician determined durable medical equipment powered mobility device was not medically necessary based on CA MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment: Powered mobility device:** 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), Power mobility devices, Exercise.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online, Pain, Powered Mobility Devices.

**Decision rationale:** The patient presents with pain affecting the low back with radiation down the left lower extremity. The current request is for Durable medical equipment: Powered mobility device. The treating physician report dated 9/1/15 (7B) states, "I would like to request authorization for a powered mobility device such as a scooter to allow him to mobilize better and for longer periods of time." The report goes on to state, "(The patient) does not have any significant problems with his upper extremities." The ODG guidelines do not support power mobility devices if the patient is able to use a cane or walker, or has sufficient upper extremity strength to use a manual wheel chair. In this case, there is no evidence provided that suggests the patient is unable to use a cane, walker, or a manual wheelchair. The current request does not satisfy the ODG guidelines as outlined in the "Pain" chapter. The current request is not medically necessary.