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| <b>Case Number:</b>   | CM15-0056186 |                              |            |
| <b>Date Assigned:</b> | 04/01/2015   | <b>Date of Injury:</b>       | 03/22/1989 |
| <b>Decision Date:</b> | 05/06/2015   | <b>UR Denial Date:</b>       | 03/07/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/24/2015 |

### 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, Pain Management

### 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 69-year-old female with an industrial injury dated 03/22/1989. Her diagnoses include chronic low back pain - degenerative lumbar spondylosis and myofascial pain syndrome, chronic neck pain - degenerative cervical spondylosis, pain disorder with psychological/general medical condition and insomnia - persistent due to chronic pain. Prior treatments include behavioral medicine, medications, pain management psychologist, and functional mobility device. She presents on 02/25/2015 with complaints of pain in low back, neck, left hip and left leg. The provider notes the injured worker has insufficient strength in her upper extremities to propel a manual wheelchair. The provider also documents her condition has deteriorated to the point where she has marked difficulty walking. The plan of care included pain management with medications and to maximize her level of physical function. The injured worker already had a mobility device and the provider was asking for the lift to transport the power scooter.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Power Mobility Device Lift:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 132. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle and Foot Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Device Page(s): 99.

**Decision rationale:** With regard to a power mobility device, the Chronic Pain Medical Treatment Guidelines specify the following on page 99 regarding 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 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." In the case of this worker, there is documentation that the worker has a powered scooter. This request is for a lift, which is an accommodation that is standard of care for those who need to transport this type of device. This is documented recently in a note dated 2/25/15. This request is medically necessary.