

Case Number:	CM14-0030654		
Date Assigned:	06/20/2014	Date of Injury:	03/18/2009
Decision Date:	07/18/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	03/10/2014

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 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:

The injured worker is a 64-year-old male who reported an injury on 03/18/2009. The mechanism of injury was not provided within the documentation. The injured worker's prior treatments were noted to be physical therapy, acupuncture, and medications. The injured worker's diagnoses were noted to be; status post hardware removal of the lumbar spine, status post fusion, and lumbar spine degenerative disc disease. The injured worker was seen for a clinical evaluation on 04/03/2014. The injured worker's chief complaint was low back pain. The physical examination of the lumbar spine revealed a healed incision in the midline, radicular pain in the lower extremity, right ankle patchy numbness, and tenderness to palpation was noted across the lumbar spine, specifically over facet joints L2-S1. There was decreased and painful range of motion noted. Motor strength was a 3/5 to 4/5 on the right L5 region. The injured worker's treatment plan was acupuncture, physical therapy, a motorized scooter, a home exercise program, medications refilled, and a pneumatic lumbar spine corset. The provider's rationale for the requested motorized scooter and lumbar spine corset were not provided within the documentation. A Request for Authorization for medical treatment was not included within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Scooter: 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.

Decision rationale: The request for a motorized scooter is non-certified. The Official Disability Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the injured worker 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. The guidelines also recommend early exercise, mobilization and independence should be encouraged at all times 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 injured worker's clinical evaluation on 04/03/2014 does not state any functional mobility deficits that would not be resolved by the prescription for a cane or a walker. The evaluation also does not provide sufficient documentation of the upper extremity function, as upper extremity function could propel a manual wheelchair. As the guidelines state, exercise should be encouraged. It was included in the injured worker's treatment plan to continue with physical therapy and home exercise, including walking. The provider's rationale for the request was not provided. The injured worker does not have sufficient evidence to meet the criteria for a powered mobility device based on the guidelines. Therefore, the request for a motorized scooter is not medically necessary and appropriate.

Pneumatic Lumbar Spine Corset: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

Decision rationale: The request for a pneumatic lumbar spine corset is non-certified. The California MTUS/American College of Occupational and Environmental Medicine Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker's low back pain is described as chronic. There is no indication that the injured worker is having any acute pain based on the evaluation on 04/03/2014. The guidelines indicate no lasting benefit and the most recent evaluation does not indicate that the injured worker is not receiving any relief from symptoms with the current treatment plan. In addition, the provider's rationale for the pneumatic lumbar spine corset was not provided within the documentation. Therefore, the pneumatic lumbar spine corset is not medically necessary.