

<b>Case Number:</b>	CM14-0060983		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	10/01/2010
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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:

This is a 65-year-old male with a date of injury of 10/1/10. The mechanism of injury occurred to his lower back while pulling a rack out of a hole. On 4/4/14, he complained of pain and numbness located in the left lower back and bilateral legs. His pain is moderate and constant, rated 6-7/10, and he is requesting a refill of his Hydrocodone. On exam his thoracic back was non-tender to palpation with no muscle spam, and pain with movement of the upper back. There was tenderness to palpation of the low back with no muscle spasm. The diagnostic impression is lumbar sprain, sciatica left, and myofascial syndrome, and lumbar spondylosis. Treatment to date includes physical therapy, medication management, and radiofrequency ablation. A UR dated 4/8/14, denied the request for an Electric Mobility Scooter purchase. Based on the diagnosis and the total lack of hard clinical indications for need for this DME or similar DME according to guidelines, the request was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME - Electric Mobility Scooter Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 132.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state that power mobility devices are 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. However, it was not noted that the patient uses or requires the assistance of a cane or walker to aid in standing or walking. It was not noted if the patient can or cannot utilize a manual wheelchair, or if there is a caregiver who can or cannot be available, willing, and able to provide assistance with a manual wheelchair. A specific rationale identifying why he requires a motorized scooter for mobility would be required in this patient despite lack of guideline support, was not identified. Therefore, the request for DME - Electric Mobility Scooter Purchase is not medically necessary.