

Case Number:	CM14-0061447		
Date Assigned:	07/09/2014	Date of Injury:	01/14/1999
Decision Date:	09/08/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/02/2014

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, has a subspecialty in Pain 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:

The patient is a 56-year-old female with a 01/14/99 date of injury. The 04/22/14 report notes state that patient returns for follow-up, she had been denied medications and is beginning to have worsening low back and radicular symptoms. She is tearful going through withdrawal and deteriorating to the point where she can longer work. Diagnoses: Status post decompression and fusion, L4-S1, complicated by infection; Status post removal of hardware; Status post revision decompression and discectomy L3-4; Intractable low back pain on opioid maintenance; Anxiety. Recurrent disk herniation at L3-4 to the right; Degenerative disk and facet disease with stenosis L1-L3; Status post permanent implantation of lumbar spine cord stimulator; Carpal tunnel syndrome; Arachnoiditis; and Failed back syndrome. Current medications include Kadian ER, morphine sulfate, and amitriptyline. The patient was prescribed MS Contin and morphine sulfate on this visit. A Progress report dated 12/24/13 states that the physician has been requesting the power scooter for the past 12 months. The request is for power scooter (rent or purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Power Scooter (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA
MTUS 2009: 9792.24.2 Page(s): 132.

Decision rationale: The physician concludes that having the use of a scooter would allow her to be able to perform her job duties more effectively and may increase her productivity by allowing her to see more clients. The MTUS Chronic Pain Guidelines state that the power mobility devices are not recommended if functional mobility deficit can be sufficiently resolved by the prescription over cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, what is the caregiver who is available willing and able to provide assistance with a manual wheelchair. The parameters mentioned in the guidelines are not addressed in the medical records provided. The VAS pain scores are not provided; functional mobility deficits are not clearly described, especially pertinent to the estimation of sufficiency of cane or a walker, and the evaluation of upper extremity function relative to the patient's ability to propel a manual wheelchair. Due to the fact that these parameters are not addressed, the certification of a powered mobility device cannot be recommended as the guidelines criteria are not met. Therefore, Power Scooter (rental or purchase) is not medically necessary.