

Case Number:	CM14-0166221		
Date Assigned:	10/13/2014	Date of Injury:	08/10/1998
Decision Date:	04/22/2015	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	10/08/2014

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. 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 53 year old male patient, who sustained an industrial injury on 09/12/2014. A primary treating office visit dated 03/18/2014 reported chief complaint of low back pain and neck pain. There is also complaint of the pain radiating down the right leg and into toes. He also complains of chronic left lower extremity weakness. The patient is deemed permanent and stationary. A repeat epidural injection was recommended. He is status post prior back surgeries. The following medications are prescribed: Soma, Lyrica, Norco and Duragesic. Physical examination found lumbar spine with decreased lordotic curvature; tenderness to palpation over L3-S1 paraspinals. A straight leg raise was negative, but with pain in the low back. There is also tenderness to palpation over the right trapezius muscles. The following diagnoses are applied: post-surgical syndrome, lumbar; lumbar radiculitis; lumbar spondylosis and myalgia. The plan of care involved refilling medications for two months, urine toxicology, physical therapy, home exercise program, injection procedure, caregiver home care, radiologic imaging, electrodiagnostic testing and follow up visit in 6-8 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement Scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Power Mobility Devices (PMDs).

Decision rationale: The injured worker sustained a work related injury on 09/12/2014. The medical records provided indicate the diagnosis of post-surgical syndrome, lumbar; lumbar radiculitis; lumbar spondylosis and myalgia. Treatments have included Soma, Lyrica, Norco and Duragesic. The medical records provided for review do not indicate a medical necessity for Replacement Scooter. There was no documented detailed examination of the upper extremities; however the examination of the lower limb revealed only slight weakness of muscle strength. Both the MTUS and the Official Disability Guidelines do not recommend the use of Power mobility devices (PMDs) 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. The records reviewed do not indicate the injured worker is unable to walk, or unable to use crutches or cane. Therefore, the request is not medically necessary.

Chair Lift: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99. Decision based on Non-MTUS Citation <http://www.ameriglide.com/wheelchair-lifts.htm>.

Decision rationale: The injured worker sustained a work related injury on 09/12/2014. The medical records provided indicate the diagnosis of post-surgical syndrome, lumbar; lumbar radiculitis; lumbar spondylosis and myalgia. Treatments have included Soma, Lyrica, Norco and Duragesic. There was no documented detailed examination of the upper extremities; the examination of the lower limb revealed only slight weakness of muscle strength. Both the MTUS and the Official Disability Guidelines do not recommend the use of Power mobility devices (PMDs) 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. Ameriglide, a manufacturer of wheel chair lifts describes wheelchair lifts as devices that enable one to carry a wheelchair or mobility scooter during travel. The medical records provided for review do not indicate a medical necessity for Chair Lift. This is based on the fact that the Replacement Scooter has been determined to be not medically necessary.