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| Case Number: | CM14-0202844 | | |
| Date Assigned: | 12/15/2014 | Date of Injury: | 02/07/2005 |
| Decision Date: | 02/05/2015 | UR Denial Date: | 11/24/2014 |
| Priority: | Standard | Application Received: | 12/04/2014 |

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 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:

This 59 year old male was injured 2/7/05. The mechanism of injury was not indicated but the injured worker experienced constant, sharp pain in the low back with radiation of pain to the right lower extremity to the thigh with numbness and weakness in the right foot and shin. In addition he experience dull to sharp right shoulder pain exacerbated with lifting, reaching overhead, pushing and pulling. The right shoulder and low back demonstrated decreased range of motion and tenderness on palpation. His diagnoses include right shoulder impingement and rotator cuff tear; status post left shoulder arthroscopic surgery with impingement syndrome; status post laminectomy (7/18/05) with residual decreased sensation right leg; degenerative joint disease of the lumbar spine. After the laminectomy he completed a course of physical therapy (number of sessions and outcome were not available). On 3/5/13 he underwent a laminectomy/discectomy L2-4. He uses a walker for ambulation and received an electric scooter to accommodate his mobility after right rotator cuff repair. His medications include Percocet, gabapentin, Cymbalta, trazodone, Protonix, diclofenac and Laxacin. With medication his pain intensity is 3/10 and without medication it is 8/10. With the use of medication he exhibits significant improvement in pain (60% decrease), improvement in function and increased ability to participate in activities of daily living and the rehabilitative process. Urine drug screen was requested to determine the current level of prescription medications but no results were documented. On 9/18/14 the injured worker underwent right shoulder arthroscopy and was gradually improving. He continued with decreased range of motion to the low back and right shoulder. Physical therapy had not started as of 10/1/14. The injured worker has not worked since date of injury. A progress report dated July 10, 2014 indicates that the patient is able to perform household duties such as cleaning, cooking, and grocery shopping. The note indicates that the patient is ambulatory with a front wheeled walker. On 11/24/14 Utilization Review non-

certified the request for continued rental of electric scooter- 3 months post op right shoulder surgery based on no documentation that functional mobility deficit cannot be sufficiently resolved by the prescription of a cane or walker, or that the injured worker has sufficient upper extremity function to propel a manual wheelchair or that there is a caregiver who is available and will be able to provide assistance with a manual wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued rental of electric scooter- 3 months post operative right shoulder surgery:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 99.

Decision rationale: Regarding the request for an electric scooter, Chronic Pain Medical Treatment Guidelines state that powered mobility devices are not recommended if the functional 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. Within the documentation available for review, it appears the patient was able to ambulate with a walker prior to the shoulder surgery. It is unclear why the patient is now unable to ambulate with an assistive device or manual wheelchair. In the absence of clarity regarding those issues, the current request for an electric scooter is not medically necessary.