

Case Number:	CM15-0130126		
Date Assigned:	07/16/2015	Date of Injury:	12/17/2009
Decision Date:	08/18/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/07/2015

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: California, Massachusetts

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:

This 41 year old female sustained an industrial injury on 12/17/09. He subsequently reported back and bilateral knee pain. Diagnoses include lumbar facet syndrome and lumbar radiculopathy. Treatments to date include x-ray and MRI testing, surgery, injections, physical therapy and prescription pain medications. MRI showed impingement on L5 nerve root with mild to moderate bilateral neural foraminal narrowing. The injured worker continues to experience low back pain. Upon examination on most recent clinic note provided from 6/10/15, antalgic gait was noted. Tenderness was noted in the thoracic and lumbar paravertebrals and over the sacroiliac spine. Straight leg raising is positive on the right side in supine position. Gaenslen's was positive in the right hip; lumbar ROM was restricted to 60 degrees flexion and 5 degrees extension. A request for Motorized scooter purchase was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized scooter purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines power mobility devices Page(s): 99.

Decision rationale: According to CA MTUS guidelines, power mobility devices such as a powered motorized scooter is "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. Early exercise, mobilization and independence should be encouraged at all steps 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." While the IW does have antalgic gate, based on the physical exam findings reviewed it appears as there is sufficient upper extremity function to enable mobility with a cane/walker/manual wheelchair. As noted in the guidelines, early mobilization and exercise facilitated by non-motorized devices is preferable. Consequently the requested purchase of motorized scooter is not medically necessary based on the provided records and cited guidelines.