

Case Number:	CM15-0166053		
Date Assigned:	09/03/2015	Date of Injury:	08/16/1990
Decision Date:	10/09/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/24/2015

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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 74 year old male with an industrial injury dated 08-16-1990. His diagnoses included multilevel lumbar arthrodesis, bilateral sacroiliac joint arthrodesis, extensive cervical spondylosis with radiculitis, intermittent; cervical facet arthrosis, multilevel cervical degenerative disc disease and non-industrial hip and knee joint degenerative disease. Prior treatment included cervical medial branch blocks, left sacroiliac joint fusion and medications. He presents on 05-22-2015 with complaints neck pain, bilateral upper extremity aching, low back pain and bilateral anterior thigh aching and stabbing pain. The provider documented the injured worker had a recent fall while working with his tools in his garage. "He is presently worse because he fell recently." Objective findings showed no focal neurologic deficits in the upper or lower extremities. He has restricted lumbar range of motion and restricted cervical range of motion. His medications included OxyContin, Percocet and Ambien. There is an order on a prescription for electric mobility scooter. The treatment request is for motorized scooter.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: The most recent attending physician reports indicate the patient has chronic neck and bilateral extremity aching, low back pain and bilateral anterior thigh aching. The current request is for a Motorized Scooter. The CA MTUS does not recommend Power Mobility Devices 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. In this case, there is no discussion as to why the patient requires a Power Mobility Device. Examination fails to provide any evidence of focal neurological deficit. The clinical information available for review is not consistent with guideline criteria, which would justify the use of a power mobility device. As such, the request for a Power Mobility Device is not medically necessary.