MAXIMUS Federal Services

Case Number:	CM15-0203407		
Date Assigned:	10/20/2015	Date of Injury:	07/24/1997
Decision Date:	12/03/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/15/2015

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
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 65 year old female who sustained an industrial injury on July 24, 1997. The worker is being treated for: sciatica, myofascitis, right hip pain, rotator cuff tear; she has been deemed as permanent and stationary; she has had multiple falls, none recent. Subjective complaint: February 28, 2014, July 17, 2014, September 09, 2014, April 01, 2015 low back pain and left hip pain. The pain medication regimen "give increased ADLs including range of motion and decreased pain:" sleeps poorly. Objective complaint: February 28, 2015, July 17, 2014, April 01, 2015, September 09, 2014 gait antalgic, spasms present. Medications: February 28, 2014, July 17, 2014, September 09, 29, 2014, April 01, 2015: Ibuprofen, Hydrocodone, Valium, and Lidoderm patches. Diagnostics: MRI. Treatment: activity modification, medication oral and topical, epidurals times four, TENS, bone marrow biopsy, shoulder injection, rotator cuff repair, treatment contracts signed for safety, diet exercise and range of motion as tolerated. On September 29, 2015 a request was made for purchase of a motor scooter that was denied by Utilization Review on October 06, 2015.

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, Section(s): Power mobility devices (PMDs).

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

Decision rationale: The patient presents on 09/29/15 with lower back pain and right hip pain rated 6-7/10. The patient's date of injury is 07/24/97. The request is for MOTORIZED SCOOTER. The RFA is dated 09/29/15. Physical examination dated 09/29/15 reveals that the patient presents in a wheelchair and ambulates with an antalgic gait. The provider notes tenderness to palpation of the lumbar spine and SI joint (unspecified), and spasms in an unspecified location. The patient is currently prescribed Lidoderm patches. Patient is currently retired. MTUS Chronic Pain Medical Treatment Guidelines, Power mobility devices (PMDs) section, page 99 states: "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." In regard to the request for a motorized scooter, the provider has the following rationale: "Scooter appropriate given LBP prompting W.C. which husband pushes and who now has been diagnosed with severe arthritis..." [sic] Progress note dated 09/29/15 notes that this patient has a history of multiple falls, and indicates that this patient's husband is no longer capable of pushing her chair. However, no physical findings of significant neurological deficit or loss of motor strength in the upper or lower extremities is provided, so it is difficult to determine if she is unable to propel herself in her wheelchair. The only examination findings pertinent to the request note that the patient ambulates with an antalgic gait and has decreased lumbar range of motion, implying that she is capable of ambulation to some extent. MTUS guidelines do not support the issuance of motorized wheelchairs in patients with sufficient upper/lower extremity function to propel a standard wheelchair, though it is not clear to what extent this patient's extremities are weakened, nor clearly stated that the patient is incapable of propelling herself. While this patient presents with a significant fall history, without demonstrated upper/lower extremity deficit, or a rationale as to why traditional assistive devices are insufficient for this patient, the requested motorized wheelchair cannot be substantiated. Therefore, the request IS NOT medically necessary.