

Case Number:	CM15-0026099		
Date Assigned:	02/18/2015	Date of Injury:	06/26/2003
Decision Date:	04/23/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/11/2015

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: Family Practice

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 66-year-old female, with a reported date of injury of 06/26/2003. The diagnoses include lumbar spine degenerative disc disease, sciatica, knee sprain, lumbar sprain, and medial meniscus derangement of knee. Treatments have included oral medications; an MRI of the lumbar spine that showed degenerative scoliosis with right-sided severe stenosis at L4-5 and L5-S1, and electromyography/nerve conduction velocity of the bilateral lower extremities, which showed bilateral L5 radiculopathy; chiropractic therapy; and physical therapy. The progress report dated 12/16/2014 indicates that the injured worker had a long-standing history of severe scoliosis. The pain was largely in the right worse than the left low back into the right buttock. The pain was occasionally in the right anterior thigh down the lateral and anterior shin. She had no numbness, paresthesias, or weakness. The injured worker's balance was compromised by her spinal deformity and pain. The objective findings included tenderness to palpation of the lumbar spine and a positive straight leg raise test bilaterally. The treating physician requested a motorized wheelchair/scooter. The rationale for the request was not indicated. On 01/09/2015, Utilization Review (UR) denied the request for a motorized wheelchair/scooter, noting that there was no documentation of upper extremity dysfunction. The MTUS Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Wheel/chair/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 medical guidelines, it states power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, 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. According to medical records, there is no indication why a motorized scooter is needed and thus not medically necessary.