

Case Number:	CM15-0026280		
Date Assigned:	02/18/2015	Date of Injury:	02/16/2007
Decision Date:	03/30/2015	UR Denial Date:	01/29/2015
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: TR, California, Virginia

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:

The injured worker is a 64 year old male, who sustained an industrial injury on 2/16/2007. The diagnoses have included cervical and thoracic sprain/strain, L5-S1 spondylolisthesis, L3-L4 lateral listhesis, L1-L4 facet arthropathy with diagnostic facet blocks, L1-S1 degenerative scoliosis, status post T9-S1 posterior spinal instrumentation and fusion, L4-S1 anterior lumbar interbody fusion and right sacroiliac joint dysfunction. Currently, the IW complains of lower back pain that radiates down the right buttocks and down the posterior aspect of the right thigh. Pain is rated as 5/10 with medication and 10/10 without medication. Objective findings included a significantly antalgic gait, mildly forward flexed. Sensation is intact in the bilateral lower extremities. There is no tenderness to palpation. Straight leg raise is positive for back pain only at 80 degrees. Computed tomography (CT) scan of the lumbar spine (11/2013) showed a posterior fusion extended from T9-L5. On the left T12-S1 neuro foraminal narrowing was noted at multiple levels. On 1/29/2015, Utilization Review non-certified a request for motorized scooter for the low back, noting that the clinical findings do not support the medical necessity of the treatment. The MTUS was cited. On 2/11/2015, the injured worker submitted an application for IMR for review of motorized scooter for low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized scooter for low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs) Page(s): 99.

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

Decision rationale: The MTUS guidelines state that such devices are 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. Overall the provided records do not provide clear indications for a motorized scooter over other modalities. With only the provided records in support of the request, per the MTUS guidelines, the request for a motorized scooter cannot be considered medically necessary.