

Case Number:	CM15-0214385		
Date Assigned:	11/04/2015	Date of Injury:	09/09/2010
Decision Date:	12/22/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/30/2015

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: Arizona, Texas

Certification(s)/Specialty: Internal 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 66 year old female, who sustained an industrial injury on 9-9-2010. A review of the medical records indicates that the injured worker is undergoing treatment for low back pain, L4 to L5 spondylolisthesis status post fusion, left foot drop, and chronic left L4 and L5 radiculitis-radiculopathy. On 10-9-2015, the injured worker reported stabbing low back pain and foot drop rating her pain as 8-10 out of 10 without the pain medications and 6-8 out of 10 with the pain medications, and reported trouble sleeping. The Primary Treating Physician's report dated 10-9-2015, noted the injured worker with a left foot orthosis, ambulating independently with a standard cane and an antalgic gait. The physical examination was noted to show tenderness on the lumbar paraspinal muscles with positive left straight leg raise. The Physician noted the injured worker had more weakness in the left lower extremity, doing well with the pain medication. The treatment plan was noted to include continued use of Norco, a recent prescription for Amitriptyline unfilled at the time, and a request for authorization for a motorized scooter as the injured worker was having trouble walking and was unable to wheel herself independently in a manual wheelchair since using her arms to propel the wheelchair caused increased low back pain. The injured worker's work status was noted to be permanent and stationary. The request for authorization dated 10-13-2015, requested Norco 10-325mg #120 and durable medical equipment (DME) purchase of a motorized scooter. The Utilization Review (UR) dated 10-20-2015, certified the request for Norco 10-325mg #120 and modification of the request for a durable medical equipment (DME) purchase of a motorized scooter to certify DME

rental of a motorized scooter for 60 days with non-certification of purchase of the motorized scooter.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME purchase of motorized scooter: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electric wheelchair.

Decision rationale: According to the ODG guidelines, a motorized wheelchair 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. In this case the patient is unable to ambulate with a cane or walker and the provider has documented that they are unable to use their upper extremities. The request for a motorized wheelchair or scooter is medically necessary.