

Case Number:	CM15-0225271		
Date Assigned:	11/23/2015	Date of Injury:	09/21/2012
Decision Date:	12/31/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	11/17/2015

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: North Carolina

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 68-year-old female, who sustained an industrial injury on 9-21-12. The injured worker was being treated for lumbar herniated nucleus pulposus, lumbar radiculopathy, cervicalgia, cervical radiculopathy, myospasms and myofascial trigger points and depression. On 7-31-15, the injured worker complains of continued low back pain with radiation to bilateral lower extremities and buttocks, rated 7 out of 10 and constant neck pain with radiation to left shoulder and bilateral upper extremities and rated 7 out of 10. She is currently not working. Physical exam performed on 7-31-15 revealed well healed incision of cervical spine with crepitus and decreased range of motion, palpable cervicothoracic muscle spasm with myofascial trigger points and pain to palpation over the occipital ridge; painful range of motion of left shoulder; and normal gait, decreased, painful range of motion of lumbar spine, palpable lumbosacral paraspinal muscle spasm with myofascial trigger points and decreased sensation in bilateral upper extremities in C7 distributions with numbness and tingling in bilateral lower extremities in L5 distributions. MRI of lumbar spine performed on 5-8-15 revealed L5-S1 and L3-5 disc protrusion, L4-5 and L1-2 disc bulge and L2-3 facet hypertrophic changes. EMG studies performed on 5-8-15 revealed moderate denervation superimposed on subacute mild denervation, absent sensory nerve conduction velocity studies for left sural and superficial peroneal sensory fibers, abnormal motor conduction velocity studies for right and left tibial and common peroneal motor fibers and prolonged late responses in form of H-reflexes and F-waves in both lower extremities. Treatment to date has included physical therapy, 2 wheel walker, oral medications including Gabapentin, Norco and Cymbalta; lumbar epidural steroid injections, home exercise program and activity modifications. The treatment plan included request for lumbar epidural steroid injections, continuation of oral medications, follow up appointment and continuation of exercises. On 10-16-15 request for 1 scooter was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scooter # 1: 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 California MTUS section on scooters 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. The patient has low back pain complaints and diagnoses but no documented upper extremity weaknesses that would require a powered mobility device. Therefore, the request is not medically necessary.