

<b>Case Number:</b>	CM15-0056251		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	12/01/1997
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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, Pain Management

### 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 56 year old female, who sustained an industrial injury on 12/1/97. The injured worker was diagnosed as having neck sprain/strain, lumbar facet syndrome, lumbar radiculopathy and left shoulder sprain/strain. Treatment to date has included Sudo scan, pulmonary stress test, oral medications including opioids and home exercise program. (EMG) Electromyogram studies were performed on 11/5/14. Currently, the injured worker complains of intermittent neck pain with radiation to left upper extremity and numbness and tingling, low back pain radiating to left lower extremity with numbness and tingling and intermittent left shoulder pain. Upon physical exam dated 2/12/15, tenderness is noted along cervical spine with decreased range of motion, tenderness along lumbar spine with decreased range of motion and decreased range of motion of left shoulder. The treatment plan included prescriptions for oral medications including opioids, continuation of home exercise program and lumbar spine surgery on 2/22/15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Scooter chair x 6 months:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Powered mobility device Page(s): 99.

**Decision rationale:** With regard to a power mobility device, the Chronic Pain Medical Treatment Guidelines specify the following on page 99 regarding power mobility devices: "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 the case of this worker, there is documentation of antalgic gait with use of cane. The patient completed several functionality questionnaires and declared inability to walk 2 blocks, pain with ascending stairs, and difficulty with prolonged standing. The provider documented that the patient is not able to buy groceries without severe pain or even walk 1/2 block. Given this level of functional impairment, a power mobility device is medically necessary.