

Case Number:	CM14-0081279		
Date Assigned:	07/18/2014	Date of Injury:	07/13/1999
Decision Date:	10/28/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	06/02/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 66 year-old Plastic Fabricator sustained an injury on 7/13/1999 while employed by [REDACTED]. Request(s) under consideration include Electric Scooter. Diagnoses include Lumbar HNP at L4-5 and L5-S1/ facet arthropathy; right hip greater trochanteric bursitis s/p bilateral total hip arthroplasties. Medications list Motrin, Elavil, Dendracin lotion, Zantac, Norco, Colace, and Zanaflex. Conservative care has included medications, therapy, injections, and modified activities/rest. Report of 11/14/13 from the provider noted the patient with ongoing chronic right hip pain with any prolonged weightbearing. There was reported improvement with medications. Exam showed patient ambulating with aid of cane; right hip has point tenderness over greater trochanteric bursa; pain free flexion and internal rotation range of motion; pain reproducible with external rotation; and globally intact motor strength in bilateral lower extremities. Treatment included medication refills and referral to another provider for second opinion on right hip pain. Report of 3/27/14 from PA-c for provider noted unchanged symptom complaints and clinical findings of right hip with exam findings of tenderness, ambulating with can with pain on range of motion. The patient was noted to have trouble with grocery shopping with request for an electric scooter along with refills of Tizanidine and Hydrocodone. The request(s) for Electric Scooter was non-certified on 5/7/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric Scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, POWER MOBILITY DEVICES (PMDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs)- Scooter, page page 100 Page(s): 100.

Decision rationale: Per MTUS Guidelines regarding power mobility devices such as scooters 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. 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. There is notation the patient has been utilizing a cane. Submitted reports noted globally intact motor strength in the upper and lower extremity muscles without clear neurological deficits. There is no physical therapy report identifying any ADL limitations or physical conditions requiring a purchase of a motorized scooter nor is there any failed trial of other non-motorized walking aide. The criteria for the power mobility device has not been met from the submitted reports. There is no documented clinical motor or neurological deficit of the upper extremities to contradict the use of the cane as the patient has been sufficiently using as a walking aide. The Electric Scooter is not medically necessary and appropriate.