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| Case Number: | CM14-0093438 | | |
| Date Assigned: | 07/25/2014 | Date of Injury: | 08/31/2000 |
| Decision Date: | 09/19/2014 | UR Denial Date: | 05/20/2014 |
| Priority: | Standard | Application Received: | 06/19/2014 |

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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:

The injured worker is a 66-year-old female who reported an injury on 08/31/2000 due to accumulative trauma. On 05/08/2014, the injured worker presented with increased pain due to increased physical activities. She had complaints of pain in the neck, head, upper back, left shoulder, left elbow, left hand, with radiation to the bilateral arms. Upon examination of the cervical spine, there was diminished sensation to the left C7 and C8 dermatomes of the upper extremity. The examination of the lumbar spine revealed no asymmetry or scoliosis and normal alignment with mild loss of lumbar lordosis. There tenderness to palpation of the bilateral lumbar paraspinal muscles consistent with spasm and sciatic notch tenderness with no piriformis spasm. There was a positive lumbar facet loading maneuver bilaterally and a positive Patrick's test. The diagnoses were lumbago, displacement of the cervical intervertebral disc without myelopathy, opioid type dependence, and chronic pain syndrome. Prior therapy included a multidisciplinary evaluation, TENS therapy, and the provider recommended an electric scooter. The provider's rationale was not provided. The Request for Authorization form was dated 04/10/2014.

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-Powered Mobility Devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Power Mobility Device.

Decision rationale: The request for an electric scooter is not medically necessary. Official Disability Guidelines do not recommend an electric scooter if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the injured worker has sufficient upper extremity function to propel 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, motorized scooters are not essential to care. As the Guidelines do not recommend a power mobility device, an electric scooter would not be warranted. Additionally, there are no objective functional deficits that were documented in relation to an unstable gait or the injured worker's inability to ambulate with a cane or walker. As such, the request is not medically necessary.