MAXIMUS Federal Services

Case Number:	CM14-0216093		
Date Assigned:	01/06/2015	Date of Injury:	09/12/1995
Decision Date:	02/28/2015	UR Denial Date:	11/28/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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: New Jersey, New York
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:

This 55 year old male sustained a work related injury on 9/12/1995. The current diagnoses are post-traumatic head and body injuries, right hand spasticity, post motor vehicle rollover, C2 fracture, and closed head injury. According to the progress report dated 11/5/2014, the injured workers chief complaints were pain in the head, spine, feet, ribs, and bilateral shoulders. The pain in the head was rated 5/10, the spine 8-9/10, feet 8/10, ribs 1-2/10, and bilateral shoulders were 8/10. The physical examination revealed spasticity of the right upper extremity. There was restricted range of motion of the shoulder. He has contractures of the right elbow and also spasm of the right hand and fingers. There is some atrophy of the right upper extremity musculature. His gait pattern is antalgic. Current medications are Ketoprofen and Prozac. On this date, the treating physician prescribed a scooter and lift for truck, which is now under review. The scooter was prescribed specifically for ambulation and the lift for truck was prescribed for traveling from point A to point B. In addition to scooter and lift for truck, the treatment plan included orthodontist/periodontist evaluation ASAP and referral to a speech language pathologist. When the scooter and lift for truck was first prescribed work status was permanent and stationary. On 11/28/2014, Utilization Review had non-certified a prescription for scooter and lift for truck. The lift for truck was non-certified based on being outside the scope of utilization review. The scooter was non-certified based on the injured worker having a caregiver, who is willing to provide assistance with a manual wheelchair. The Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Motorized scooter, knee/leg

Decision rationale: The request is considered not medically necessary. There are no MTUS guidelines for scooter use, therefore, ODG guidelines were used. According to ODG, if there is a willing caregiver who is able to provide assistance with a manual wheelchair, a motorized scooter is not recommended. The patient has a sister who cares for the patient on a daily basis. Therefore, a motorized scooter is not medically necessary at this time.

1 lift for truck: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain (chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ?Reference/Citation: Anthem, Clinical UM Guideline, Subject: Durable Medical Equipment, Guideline#: CG-DME-10. Curretn (April 11, 2012) and Medicare CMS patient lift references

Decision rationale: MTUS and ODG guidelines do not address the use of a lift. However, according to the utilized guidelines, an electric lift is not medically necessary. The patient can have alternate means of transport with the aid of his caregiver. There is no indication that a truck lift will improve the patient?s condition. Therefore, the request is considered not medically necessary.