

Case Number:	CM14-0218259		
Date Assigned:	01/07/2015	Date of Injury:	07/10/2004
Decision Date:	03/12/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/30/2014

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:

The injured worker is a 43 year old male who suffered a work related injury on 07/10/04 when he fell on ice and fell backwards several times on the same day. Per the physician notes from 11/19/14 he receives Opioids for neck back and leg pain. His current pain level is 8/10. The lumbosacral spine was noted to be exquisitely tender and spasm was noted. The pain was described as severe, constant ache, and deep. The pain refers bilaterally to hips, low back and posterior legs. Diagnoses include chronic low back pain, chronic use of opiate drugs, and failed back syndrome, lumbar. Recommended treatments include Naprosyn, Trazadone, Xanax, Percocet, and a scooter. The scooter was denied by the Claims Administrator on 12/04/14 and was subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scooter: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices Page(s): 99. Decision based on Non-MTUS Citation Motorized scooter, knee/leg

Decision rationale: The request is considered not medically necessary. According to MTUS if the patient can ambulate with cane or walker or has upper extremity strength to propel a manual wheelchair, then a motorized scooter is not necessary. 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 is ambulatory and is not documented to be unable to use upper extremities to propel himself if a manual wheelchair was used. He also lives with his family who would be able to provide assistance. Therefore, a motorized scooter is not medically necessary at this time.