

Case Number:	CM15-0112210		
Date Assigned:	06/18/2015	Date of Injury:	01/07/2005
Decision Date:	07/17/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/10/2015

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: Emergency Medicine

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 45 year old male, who sustained an industrial/work injury on 1/7/05. He reported initial complaints of pain in neck, lower back, and shoulder areas. The injured worker was diagnosed as having pain in limb, sprains/strains of neck and lumbar region, brachial neuritis, radiculitis not otherwise specified, thoracic or lumbosacral neuritis, shoulder region disorders, enthesopathy of wrist, Pes Anserinus tendinitis or bursitis. Treatment to date has included medication, diagnostics, psychiatric care, and neurology. Currently, the injured worker complains of chronic neck, lower back, and shoulder pain along with weakness in right side of body s/p stroke. There was difficulty performing activities of daily living. Sleep is interrupted due to pain. Per the primary physician's progress report (PR-2) on 5/4/15, examination reveals antalgic gait and uses a cane for ambulation. The requested treatments include one electric scooter.

IMR ISSUES, DECISIONS AND RATIONALES

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

One electric scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 99, Power Mobility Devices Page(s): 99.

Decision rationale: The requested one electric scooter , is not medically necessary. CA MTUS 2009, Chronic Pain Treatment Guidelines, Page 99, Power Mobility Devices, note "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, if the patient has sufficient upper extremity function to propel a manual wheelchair, or if a caregiver is available, willing, and able to provide assistance with a manual wheelchair." The injured worker has chronic neck, lower back, and shoulder pain along with weakness in right side of body s/p stroke. There was difficulty performing activities of daily living. Sleep is interrupted due to pain. Per the primary physician's progress report (PR-2) on 5/4/15, examination reveals antalgic gait and uses a cane for ambulation. The treating physician has not documented insufficient upper extremity function to utilize a manual wheelchair. The criteria noted above not having been met, one electric scooter is not medically necessary.