

Case Number:	CM15-0178756		
Date Assigned:	09/21/2015	Date of Injury:	01/23/2014
Decision Date:	10/29/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/11/2015

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: Physical Medicine & Rehabilitation

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 57-year-old male with an industrial injury dated 01-23-2014. Medical record review indicates he is being treated for cervicogenic headache frontal in nature, mild closed head injury, and bilateral shoulder impingement syndrome, bilateral adhesive capsulitis, left AC joint arthritis, cervical sprain and strain, thoracic fractures at thoracic 6, thoracic 9 and lumbar 1 vertebrae and sternal pain and left rib pain. Prior surgeries included right shoulder arthroscopy with joint debridement, acromioplasty and calcium removal done on 07-14-2014 and left shoulder arthroscopy with acromioplasty and joint debridement on 05-14-2014. The progress note dated 07-22-2015 documents the injured worker presents with thoracic pain, bilateral shoulder pain, left rib pain, lung pain and headaches. He stated "his pain is worse with sharp, burning, throbbing, pins and needles, tingling and numbness." The treating physician documented the pain was constant and brought on with any position and activity. The treating physician also documents the injured worker is not in any active therapy, no new symptoms and he has been off work for work restrictions. Objective findings (thoracic spine) are documented as tenderness in the paravertebral area and range of motion was within normal functional limits. Neurological exam of lower extremity findings are documented as motor strength 5 out of 5, light touch sensation by dermatome (lumbar 2, 3, 4, 5 and sacral 1) was intact. Gait is documented as normal. Range of motion of lumbar is documented as 60 degrees flexion, 25 degrees extension, and right lateral flexion and left lateral flexion and 30 degrees right and left rotation. The following tests were documented as negative-seated straight leg raise bilaterally, femoral stretch testing, supine straight leg raising bilaterally, Faber test, Piriformis stretch and facet load test. In the progress note dated 06-11-2015 the treating physician notes; "This gentleman is using a cane, he is heavily dependent on the cane, he is using in his right hand." His medications included Norco, Cymbalta,

Lyrica, Nortriptyline and Anaprox. Prior treatments included physical therapy, aqua therapy and medications. Acupuncture was put on hold due to the possibility of surgery. The treatment plan is for medications, TENS unit, vertebroplasty and for mobility scooter. The treatment request is for powered mobility scooter (unspecified if rental or purchase.) On 08-28-2015 the request for powered mobility scooter (unspecified if rental or purchase) was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Powered mobility scooter (unspecified if rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter - Power Mobility Devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: Based on the 7/22/15 progress report provided by the treating physician, this patient presents with constant thoracic pain, bilateral shoulder pain, left rib pain, lung pain, and headaches. The treater has asked for powered mobility scooter (unspecified if rental or purchase) on 7/22/15 so that he can go on social activity. The request for authorization was not included in provided reports. The patient states that his pain is worsening, with sharp, pins/needles, numbness/tingling sensation that is brought on with any position and activity per 7/22/15 report. The patient is s/p constipation while on Norco, but is able to function with it per 7/22/15 report. The patient was authorized for acupuncture but is being put on hold for treatment due to pending surgical consideration per 8/29/15 report. The 7/22/15 report states: "The patient's gait pattern is normal." The patient's work status is off work for work restrictions per 7/22/15 report. MTUS Guidelines, Power Mobility Devices Section, page 99 states: "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." No request for authorization was included in provided documentation. Review of reports dated 5/28/15 to 8/19/15 do not provide any indication that the patient has difficulty ambulating; in fact, the patient's gait pattern is described as "normal." There are no physical findings of significant neurological deficit or lack of motor strength in the upper extremity that would prevent this patient from using a manual wheelchair. MTUS does not support the issuance of motorized scooter/wheelchair in patients with sufficient upper extremity function to propel a standard wheelchair. The requested electric scooter cannot be substantiated. The request is not medically necessary.