

<b>Case Number:</b>	CM15-0070563		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	07/30/1999
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 65 year old male, who sustained an industrial injury on July 30, 1999. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having lumbago, lumbar radiculopathy, failed back syndrome, chronic pain syndrome, right cervical radiculopathy, and a history of right hand and finger injury. Diagnostics to date has included urine drug screening. Treatment to date has included home exercise program, moist heat, stretching, psychotherapy, a cane, and short-acting opioid, long acting opioid, anti-anxiety, antidepressant, and anti-epilepsy medications. On February 27, 2015, the injured worker complains of constant neck, lower back pain radiating to bilateral lower extremities, and bilateral hand pain. The pain was described as sharp, dull/aching, throbbing, pins & needles, stabbing, numbness, electrical/shooting, burning, stinging, cramping, weakness, and spasm. His pain was rated 5 on his previous and current good days. On his previous and current bad days, his pain was rated 8. The physical exam revealed no right little finger with scars on the 2nd-4th fingers, use of right wrist and forearm orthotics, and right wrist, hand, and forearm tenderness. There was diffuse cervical tenderness with limited range of motion due to pain. The lumbar/sacral exam revealed a lumbar spine scar, positive bilateral straight leg raises, severe tenderness of the lower lumbar facet joint and sacroiliac joints, decreased range of motion, sciatic notch tenderness. The motor exam revealed a slow gait with use of a cane in the right hand, inability to toe and heel walk, and the inability to move the feet, ankles, and toes with diffuse weakness of the upper and lower extremities due to pain. There was decreased sensation of the upper and lower extremities, absent deep tendon reflexes of the

bilateral knees and ankles, and decreased deep tendon reflexes on the upper extremities. The treatment plan includes a referral to physiatrist for motorized wheel chair/scooter.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Referral to Physiatrist for Motorized Wheel Chair/Scooter: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289, Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

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

**Decision rationale:** The MTUS Chronic Pain guidelines address the use of motorized mobility devices, stating that they are 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. In this case, it appears that the patient has been able to use a cane for improved mobility. 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. Overall, the provided records do not provide clear indications for a motorized scooter over other modalities. With only the provided records in support of the request, per the MTUS guidelines, the request for a motorized wheelchair cannot be considered medically necessary, and therefore the consultation to obtain such a device is not medically necessary.