

<b>Case Number:</b>	CM15-0084412		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	11/26/2008
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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 50 year old male who sustained an industrial injury on 11-26-2008. Treatment to date has included surgery, physical therapy, spinal injections and medications. According to a progress report dated 03-10-2015, the injured worker was seen for chronic low back pain with radiation into the bilateral lower extremities and weakness in the left leg (stable). He continued to experience cramping in his left leg and left abdomen. Medications included Oxycodone, Baclofen and Gabapentin. The provider noted that a prior request for a lift for the injured worker's car to accommodate his scooter was still pending. Without the lift, he could only use the scooter around his home and not for such activities as grocery shopping, "where he really needed it". Gait appeared to be antalgic and shuffled. With cane, anterior flexion was noted to be 5 degrees. Diagnoses included failed back syndrome lumbar, insomnia unspecified, unspecified neuralgia neuritis and radiculitis and radiculopathy lumbar spine. The provider noted that the injured worker knew to use the scooter only as needed for prolonged activity. He was to continue to ambulate as much as possible with his cane for preservation of function. Medications prescribed included Oxycodone, Baclofen and Gabapentin. On 04-20-2015, Utilization Review non-certified the request for one purchase-rental of a scooter trailer as an outpatient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One purchase/rental of a scooter trailer as an outpatient: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs). Decision based on Non-MTUS Citation Aetna [www.aetna.com/cpb/medical/data/400\\_499/0459.html](http://www.aetna.com/cpb/medical/data/400_499/0459.html).

**Decision rationale:** The patient presents with pain in the lumbar spine radiating to the bilateral lower extremities. The request is for One purchase/rental of a scooter trailer as an outpatient. Patient is status post lumbar spine surgeries, 2009 and 2010. Physical examination to the lumbar spine on 03/10/15 revealed tenderness to palpation over the intervertebral spaces. Range of motion was restricted with pain. Straight leg raising was positive bilaterally. Patient had an antalgic gait and used a cane for ambulation. Per 07/28/15 Request for Authorization, patient's diagnosis include lumbar and sacral spondyloarthritis, and chronic pain syndrome. Patient's work status was not specified. MTUS Chronic Pain Medical Treatment, Power Mobility Devices section, pg 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." Aetna, [aetna.com/cpb/medical/data/400\\_499/0459.html](http://aetna.com/cpb/medical/data/400_499/0459.html), does not cover the following types of lifts because they do not meet Aetna's contractual definition of covered DME: Van lifts (used to lift wheelchair into a truck or van), Wheelchair lifts or ramps (e.g., Wheel-O-Vator lift) (provides access to stairways or car trunks). In progress report dated 03/10/15, the treater states that the patient has his scooter and needs a lift for his car so he can use it for activities outside of home. MTUS allows for power mobility devices when cane, walker or manual wheelchair is not feasible due to upper extremity weakness and if there is no mobility with a cane or other assistive devices. In this case, although the patient already has a scooter, the patient is able to ambulate with the use of a cane. The use of a power mobility device would not be in accordance with guidelines for this patient, thus this associated request for a trailer for the continued use of his scooter cannot be warranted. In addition, car lifts do not meet "contractual definition of covered DME" according to Aetna Guidelines. Therefore, the request IS NOT medically necessary.