

<b>Case Number:</b>	CM15-0099311		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	09/15/1999
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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 58 year old male, who sustained an industrial injury on 9/15/99. He reported injuring his back after being tossed around in a basket lift. The injured worker was diagnosed as having chronic intractable low back pain secondary to multilevel lumbosacral degenerative disc disease, severe neuropathic pain with radiculopathy and chronic pain syndrome. Treatment to date has included seven spinal fusions, physical therapy, a spinal cord stimulator and aqua therapy which is beneficial. Current medications include Oxy IR, Oxycodone and Miralax. On 12/4/14, the injured worker reported difficulty getting up from seated to standing position. As of the PR2 dated 3/30/15, the injured worker reports having difficulty walking and is experiencing extreme fatigue. His wife is pushing him in a manual wheelchair and he is wearing a lumbar brace. Objective findings include decreased breath sounds and tenderness to palpation to the lumbar paraspinal. The treating physician requested a replacement electric scooter and lift.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Replacement Electric Scooter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 106.

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

**Decision rationale:** The patient presents with low back pain. The request is for electric scooter qty: 1.00. Physical examination to the lumbar spine on 12/04/14 revealed tenderness to palpation to the palpation to the paraspinals. Range of motion was decreased in all planes. Patient has a stooped posture. Patient's treatments have included medications, spinal cord stimulator, back brace, physical therapy and aquatic therapy with benefits. Patient's diagnosis, per 11/06/14 progress report include chronic intractable low back pain secondary to multilevel lumbosacral degenerative disc disease, severe neuropathic pain, status post spinal cord stimulator placement for lumbar stenosis, chronic pain syndrome, opioid dependence, and history of constipation. Patient's medications, per 02/24/15 progress report include Oxy IR and MiraLax. Patient's work status was not specified. Power Mobility Devices under MTUS 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." In progress report dated 03/30/15, treater states, "He is being pushed on a manual wheelchair. The reason being is that it is difficult for him to walk. The patient has been experiencing severe fatigue and exhaustion" and "Requesting authorization for an electric scooter since his scooter has not been working." 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, the patient does not present with any organic reasons for upper extremity weakness other than from fatigue and chronic pain. There is evidence also that the patient is not able to walk, particularly with walking aids such as a walker or cane. The request does not meet guideline recommendations and therefore, it is not medically necessary.

**Lift for Electric Scooter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMD) Page(s): 106.

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

**Decision rationale:** The patient presents with low back pain. The request is for lift for electric scooter qty: 1.00. Physical examination to the lumbar spine on 12/04/14 revealed tenderness to palpation to the palpation to the paraspinals. Range of motion was decreased in all planes. Patient has a stooped posture. Patient's treatments have included medications, spinal cord stimulator, back brace, physical therapy and aquatic therapy with benefits. Patient's diagnosis, per 11/06/14 progress report include chronic intractable low back pain secondary to multilevel

lumbosacral degenerative disc disease, severe neuropathic pain, status post spinal cord stimulator placement for lumbar stenosis, chronic pain syndrome, opioid dependence, and history of constipation. Patient's medications, per 02/24/15 progress report include OxyIR and MiraLax. Patient's work status was not specified. Power Mobility Devices under MTUS 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." Treater has not provided reason for the request. 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. Since an electrical scooter would not be indicated according to guidelines, a lift for the electric scooter would not be indicated either. Therefore, the request is not medically necessary.