
Notice of Independent Medical Review Determination

Dated: 10/7/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/11/2013

7/2/2010

7/22/2013

CM13-**0002543**

- 1) MAXIMUS Federal Services, Inc. has determined the request for motorized scooter **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for motorized scooter **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Preventative Medicine and Occupational Medicine, and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 11, 2013:

“According to the clinical documentation, the patient is a 64-year-old who sustained an injury on 7/02/10. The mechanism of injury was not documented in the medical reports submitted with this request. PR-2 dated 6/24/13 by Dr. [REDACTED], documented the patient complained of continued pain and was not currently working. Additional treatment requested that included additional physical therapy and pain psychologist sessions were denied. Dr. [REDACTED] stated that this was an extensive case involving multiple body parts. Patient brought in information regarding a motorized wheelchair. This piece of equipment was previously requested and denied. Patient was accompanied by a relative. This patient required 24/7 care which was being provided by the relatives at the present time. Treatment plan include a request for motorized scooter. Office visit note dated 6/17/13 by Dr. [REDACTED], documented the patient's current medications were the following: 1) Colace 100 mg capsule taken up to three times a day as needed, 2) Norco 10/325 g tablet taken every four hours as needed for pain (maximum of six tablets per day), 3) Ondansetron 4 mg tablet taken bid as needed for nausea and vomiting, 4) Pennsaid 1.5% solution applied 40 drops to knees up to QID as needed for pain and inflammation, 5) tizanidine hcl 2 mg tablet to be taken one half tablet every 12 hours pro for muscle spasms, 6) trazodone 50 mg tablet to be taken one half tablet to one tablet at bedtime, 7) isosorbide 5 mg tablet sublingual, 8) Lipitor 10mg tablet, 9) Nitroquick 0.3 mg tablet sublingual and 10) Plavix 75 mg tablet. The patient was status post knee replacement surgeries on both knees. Patient remained largely wheelchair dependent. Patient utilized Townsend braces on both knees. Patient ambulated when at home but in a limited fashion. Patient discussed the desire to be provided a motorized scooter to help improve independence and ability to become more independent. Patient was frustrated in having to rely on daughter for help. Patient appeared to be significantly depressed and emotionally distraught over the situation.

“From past assessments and reports, the patient was in need of comprehensive interdisciplinary treatment in order to improve due to the combination of functional limitations, significant chronic pain issues and significant adjustment disorder as well as dependence on medications like hydrocodone. Initial baseline treatment for the patient was denied and as a result treatment Dr. [REDACTED] had not moved forward with any semblance of rehabilitation plan for the patient. Patient was scheduled for a Qualified medial evaluation (QME) on 7/31/13. Dr. [REDACTED] would like to consider inpatient rehabilitation program. Dr. [REDACTED] would like to request for an electronic motorized scooter for this patient as nothing else was being offered to improve the level of functionality at this time. Peer review report dated 5/02/13 by Dr. [REDACTED] documented previous treatment included knee braces, medications and physical therapy. According to Office visit note dated 6/17/13 by Dr. [REDACTED], the patient was diagnosed with cervicalgia, joint pain on left leg, lumbar and lumbosacral disc degeneration, lumbago, anxiety state, depressive disorder, lumbosacral spondylosis, sciatica and psychogenic pain. This is a request for medical necessity of motorized scooter.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Medical Records from the Law Offices of [REDACTED], PC
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for motorized scooter:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Power mobility devices (PMDs), page 99. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on July 10, 2010 to the lower back, right and left knees. The medical records provided for review indicate diagnoses of lumbar pain, sciatica, anxiety and depression and with psychogenic pain. The employee has had bilateral knee replacements. The request is for a motorized scooter.

The MTUS Chronic Pain Guidelines indicate that powered mobility devices 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 push a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. The medical records provided for review do not indicate that other mobility devices were tried, or that the employee has limited upper extremity function. The medical records

indicate that the employee has caregivers who can assist her with a manual wheelchair. The request for a motorized scooter **is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.