

Case Number:	CM13-0054889		
Date Assigned:	01/31/2014	Date of Injury:	02/12/2008
Decision Date:	05/08/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/20/2013

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. The expert reviewer is Board Certified in 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 62-year-old female with a 2/12/08 date of injury. At the time (10/22/13) of request for authorization for motorized scooter, there is documentation of subjective findings (increasing pain and stiffness about the bilateral hips, pain rated 8-9/10, increasing pain and grinding about the right hip; bilateral thumb pain and left shoulder pain, pain exacerbated with reaching and lifting activities at and above shoulder level) and objective findings (patient confined to a wheelchair, tenderness over the basal or carpal metacarpal joints about both thumbs, decreased range of motion, particularly upon flexion of the thumbs at the CMC joints secondary to pain; tenderness about the anterior capsule of the left shoulder, associated muscle spasms and myofascial trigger points about the upper trapezius and posterior scapular muscles, decreased range of motion; tenderness about the greater trochanteric bursa regions of both hips, bilateral hip range of motion moderately decreased secondary to increased pain, positive Patrick's at both hips). The current diagnoses include strain/sprain lumbar spine, multilevel degenerative disc disease (DDD) and posterior disc protrusions; active L5-S1 left-sided radiculopathy, bilateral hip labral tears, status post left shoulder rotator cuff repair, degenerative arthritis of the basal joints, bilateral thumbs; sprain/strain/contusion of the left thumb; iliotibial band and greater trochanteric bursitis. The treatment to date includes use of a wheelchair, medications, splinting, bilateral thumb cortisone injections, and activity modification). The 10/1/13 medical report identified that due to the patient's complaints of moderate to severe bilateral hip pain, and her inability to effectively bear weight about her bilateral hips, in conjunction with her bilateral basal joint arthritis that prevents her from hand wheeling herself about in her wheelchair, and as per recommendations of the agreed medical exam (AME), a request is made for the patient to be provided with a motorized scooter to help her get around during the normal course of her normal daily activities. The 11/15/13 patient's

letter identified, "I cannot use a standard wheelchair because my fingers and thumbs are in such bad shape." "My husband had to retire due to a hip replacement and neuropathy in his feet. He cannot continue to lift the wheelchair out of the car and push me indefinitely."

IMR ISSUES, DECISIONS AND RATIONALES

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

MOTORIZED SCOOTER: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES. Decision based on Non-MTUS Citation THE ODG, PAIN, POWER MOBILITY DEVICES (PMDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES Page(s): 135.

Decision rationale: The Chronic Pain Medical Treatment Guidelines identifies documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker; the patient has insufficient upper extremity function to propel a manual wheelchair; and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair, as criteria necessary to support the medical necessity of a scooter. Within the medical information available for review, there is documentation of diagnoses of strain/sprain of the lumbar spine, multilevel degenerative disc disease (DDD) and posterior disc protrusions; active L5-S1 left-sided radiculopathy, bilateral hip labral tears, status post left shoulder rotator cuff repair, degenerative arthritis of the basal joints, bilateral thumbs; sprain/strain/contusion of the left thumb; iliotibial band and greater trochanteric bursitis. In addition, there is documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, that the patient has insufficient upper extremity function to propel a manual wheelchair, and that there is no caregiver who is able to provide assistance with a manual wheelchair. Therefore, based on guidelines and a review of the evidence, the request for motorized scooter is medically necessary.