

<b>Case Number:</b>	CM14-0175987		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	07/13/2010
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	10/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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:

This is a 55-year-old female with a 7/13/10 date of injury. According to a report dated 10/1/14, the patient complained of left lower extremity knee to foot pain that was rated between an 8 and a 10. The pain was described as burning, electrical, and throbbing. She also complained of left knee soreness which she attributed to the use of her knee scooter. The patient has been having increasing right knee instability and left knee pain with the use of the knee scooter. Objective findings: guarding of affected limbs, muscle spasms, joint swelling and stiffness of left ankle. Diagnostic impression: complex regional pain syndrome. Treatment to date: medication management, activity modification, aqua therapy, home exercise program. A UR decision dated 10/9/14 denied the request for motorized scooter. MTUS guidelines note that alternate and lower level options should be discussed and increased deconditioning may be expected with motorized scooter use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized Scooter quantity 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Integrated Treatment/Disability Duration Guidelines, Power mobility devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 132.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that power 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 propel 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 show the employee's impairment to basic activities of daily living, and there is no clear documentation on the degree of impairment affecting the ability to walk. In addition, the medical records provided for review do not indicate that the patient does not have caregivers who can assist her with a manual wheelchair. Therefore, the request for Motorized Scooter quantity 1.00 is not medically necessary.