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| <b>Case Number:</b>   | CM15-0103647 |                              |            |
| <b>Date Assigned:</b> | 06/08/2015   | <b>Date of Injury:</b>       | 05/30/2012 |
| <b>Decision Date:</b> | 07/10/2015   | <b>UR Denial Date:</b>       | 05/04/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/29/2015 |

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 57-year-old female who sustained an industrial injury on 05/30/2012. Treatment provided to date has included: physical therapy, injections to the left heel, lumbar injections, medications, shockwave therapy, right knee surgery, psychological therapy, and conservative therapies/care. Diagnostic tests performed include: MRI of the cervical spine (01/16/2015) showing multilevel disc protrusions and degenerative changes. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 04/21/2015, physician progress report noted complaints of neck pain, right shoulder pain, right hand pain, back pain (old but aggravated on 05/30/2012), right hip pain, right knee pain, and left foot symptoms. Additional complaints include limited range of motion in the neck and increased migraine headaches. The physical exam revealed left knee snapping with extension, left ankle stiffness, tenderness at the base of the metatarsal heads, and trace edema in the left lower extremity. The provider noted diagnoses of status post fall, right CMC arthritis, right knee meniscal injury, left heel plantar fasciitis, and right low back pain. The injured worker was reported to have had a previous lumbar epidural steroid injection with good results. Plan of care includes left tarsal tunnel release, a mobility scooter, epidural steroid injection, plantar fasciitis supports, right hand brace/support and baclofen. The injured worker's work status was permanent and stationary. Requested treatments include mobility scooter for 3 months and epidural steroid injection at the right L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Mobility scooter (in months) Qty: 3. 00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**Decision rationale:** According to MTUS guidelines, Power mobility devices “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.” There is no documentation that the patient has a mobility deficit with a cane or a walker and the need for a scooter is not clear. Therefore, the request for Mobility scooter (in months) Qty: 3. 00 is not medically necessary.

**Epidural steroid injection at right L5-S1 Qty: 1. 00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit; however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no evidence that the patient has been unresponsive to conservative treatments. Furthermore, there is no recent clinical and objective documentation of radiculopathy including MRI or EMG/NCV findings. MTUS guidelines do not recommend epidural injections for back pain without radiculopathy. There is no clear documentation of radiculopathy at the level of L5-S1. Therefore, Epidural steroid injection at right L5-S1 Qty: 1. 00 is not medically necessary.