

Case Number:	CM15-0160241		
Date Assigned:	08/26/2015	Date of Injury:	07/17/2012
Decision Date:	09/29/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/17/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 42 year old female, who sustained an industrial injury on 7-17-2012. Diagnoses include complex regional pain syndrome. Treatment to date has included implantation of a spinal cord stimulator (undated) with revision and replacement of leads (4-14-2014), as well as conservative measures including medications, stellate ganglion block (5-05-015), ketamine infusions, and injections. Per the Primary Treating Physician's Progress Report dated 5-01-2015, the injured worker reported severe pain in the left foot with color changes, allodynia and hyperesthesia. She reports new left arm pain, and continuation of right buttock, right shoulder, right elbow, and right wrist pain. Physical examination revealed mild, generalized swelling and tenderness. Muscle strength and joint motion were reduced on the left side. The plan of care included, and authorization was requested for an ankle brace and a motorized scooter.

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 ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines powered mobility device Page(s): 99.

Decision rationale: According to the guidelines, motorized scooter is 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 this case, the claimant has CRPS with pain in the left foot and weakness in the left arm. As a result, the ability to ambulate, use a walker or manual wheelchair is difficult. The request for the motorized scooter is medically necessary.