

<b>Case Number:</b>	CM15-0031853		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	01/16/2001
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 66-year-old female who reported an injury on 01/16/2001. The mechanism of injury involved heavy lifting. The current diagnoses include tendonitis and impingement of the right shoulder, right rotator cuff tear, status post left foot surgery on 06/05/2003, and recent fall sustaining sprain/strain of the left ankle. The injured worker presented on 01/26/2015 with complaints of left ankle pain. It was noted that the injured worker reported a fall secondary to left ankle pain and instability. The injured worker was afraid to leave the house secondary to falling. The injured worker was utilizing Tylenol No. 3. Associated complaints included numbness and tingling in the muscles and weakness of the ankle, shoulder, hip, and left foot. Upon examination of the left ankle, there was tenderness to palpation with 50% range of motion in all planes. There was 4+/5 motor weakness throughout the ankle. There was no edema, swelling or varicosities noted. Recommendations included a motorized scooter. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized Scooter:** 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).

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

**Decision rationale:** The California MTUS Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or a walker. In this case, there was no indication that the injured worker requires a power mobility device as opposed to a cane, walker, or manual wheelchair. There was no indication that this injured worker could not sufficiently propel a manual wheelchair. There was also no documentation of a significant functional limitation upon examination. Given the above, the request is not medically appropriate.