

<b>Case Number:</b>	CM15-0082817		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	02/05/2015
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 54 year old female, who sustained an industrial injury on 2/5/15. She reported right arm, right knee, right ankle, right wrist and lower back pain. The injured worker was diagnosed as having wrist/hand sprain/strain, contusion of wrist, lumbar sprain/strain and right ankle sprain/strain. Treatment to date has included wrist support, oral medications including NSAIDS, physical therapy, chiropractic treatment and home exercise program. Currently, the injured worker complains of worsening sharp, moderately severe pain in back and right wrist. The injured worker states medications is tolerated and she is working regular duties. Physical exam noted tenderness to palpation of thoracolumbar spine and paravertebral musculature with restricted range of motion and tenderness to palpation of extensor surface of right wrist with full range of motion. The treatment plan included oral medications including acetaminophen and Nabumetone. The treatment plan included continued physical therapy, chiropractic treatment and oral medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Roller 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), Knee Chapter, Power mobility devices (PMDs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg section; DME, Power mobility device.

**Decision rationale:** Pursuant to the Official Disability Guidelines, roller scooter is not medically necessary. Durable medical equipment is recommended generally if there is a medical need and the device or system meets Medicare's definition of durable medical equipment. Most bathroom and toilet supplies do not customarily serving medical purpose and are primarily used for convenience in the home. The term DME is defined as equipment which: can withstand repeated use; is primarily and customarily served medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in the patient's home. Power mobility devices (PMD) 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. 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 injured worker's working diagnoses are concussion with loss of consciousness; sprain/strain wrist/hand unspecified; contusion wrist; and sprain/strain lumbar. Subjectively, according to an April 3, 2015 progress note, the injured worker complaints of headache; back pain. There is no leg weakness or numbness or tingling of the lower extremities. The injured worker has pain and limited motion of the right wrist. Subjective section states DME is helping with the injured worker's symptoms. The documentation does not explain what DME is assisting with what symptoms. Objectively, the injured worker has an abnormal gait. There is no description of the "abnormal gait" in the medical record. Right wrist is tender palpation. The right wrist is otherwise stable. Heel/toe ambulation is performed without difficulty, reflexes are normal and sensation is normal in the lower extremity dermatomes. There are no subjective complaints or objective clinical findings and medical record showing a mobility device (roller scooter) is clinically indicated. There is no documentation showing the injured worker cannot achieve mobility of the cane or other assistive device based on the clinical findings in the medical record. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, roller scooter is not medically necessary.