

<b>Case Number:</b>	CM15-0119899		
<b>Date Assigned:</b>	06/30/2015	<b>Date of Injury:</b>	10/17/2005
<b>Decision Date:</b>	07/30/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 62 year old female, who sustained an industrial injury on October 17, 2005, incurring multiple injuries. She was diagnosed with knee tendinitis, wrist tendinitis, elbow, knee and ankle bursitis, shoulder impingement, cervical radiculopathy and lumbosacral radiculopathy. Treatment included physical therapy, chiropractic sessions, home health care, rotator cuff repair, diagnostic imaging, anti-inflammatory drugs, pain medications and work modifications. Currently, the injured worker complained of continued chronic neck and lower back pain, bilateral shoulder and wrist pain. She had difficulty with bending, stooping, squatting and prolonged standing, repetitive motions and overhead activities. She complained of muscle spasms and tenderness of the cervical and lumbar spine with decreased range of motion on flexion and extension. Upon examination, it was noted that she walked with an antalgic gait. The treatment plan that was requested for authorization included a motorized scooter and wrist brace and ankle brace.

### 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, knee, durable medical equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Motorized scooter is not medically necessary.

**Wrist brace and an ankle brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 16-17.

**Decision rationale:** According to the MTUS, wrist and ankle supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Based on the patient's stated date of injury, the acute phase of the injury has passed. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Wrist brace and an ankle brace are not medically necessary.