

<b>Case Number:</b>	CM13-0072063		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/11/2012
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Minnesota. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 36-year-old female who reported an injury on 07/11/2012. The mechanism of injury involved a motor vehicle accident. Current diagnosis is status post ORIF of bilateral knee fractures with posttraumatic arthritis/chondromalacia. The injured worker was evaluated on 04/01/2014. The injured worker reported 7/10 pain in bilateral knees. Previous conservative treatment includes medication management, multiple sessions of physical therapy and an intra-articular cortisone injection into the left knee. Physical examination revealed no acute distress, positive log roll testing, 0 to 125 degree range of motion of the right knee, 0 to 95 degree range of motion of the left knee, tenderness to palpation at the medial and lateral joint line of bilateral knees, intact sensation and 5/5 motor strength. Treatment recommendations at that time included a possible diagnostic arthroscopy with hardware removal and a motorized scooter or wheelchair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF A MOTOR SCOOTER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES.

**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 walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available and willing to provide assistance with a manual wheelchair. The injured worker does not currently meet criteria for the requested durable medical equipment. Physical examination revealed intact sensation with 5/5 motor strength in bilateral lower extremities. There is no evidence of a significant musculoskeletal or neurological deficit. There is no indication that this injured worker cannot self-propel a manual wheelchair. There is also no indication that this injured worker does not maintain assistance from a caregiver who is available, willing and able to provide assistance with a manual wheelchair. As the medical necessity has not been established, the current request is non-certified.