

Case Number:	CM14-0101696		
Date Assigned:	07/30/2014	Date of Injury:	10/23/2009
Decision Date:	09/19/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/01/2014

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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 61 year old with an injury date on 10/23/09. According to progress report 5/19/14, the patient complains of chronic pain in buttocks radiating into bilateral lower extremity, described as tingling and intermittent. Patient has increase in pain with prolonged sitting, standing, and walking, and stretching alleviates her pain. Based on the 5/19/14 progress report provided by [REDACTED] the diagnoses are: 1. fibromyositis 2. chronic pain syndrome 3. pain in limb 4. sprain of ankle, unspecified site 5. closed fracture of navicular bone of foot Exam on 5/19/14 showed "antalgic gait favoring right. Patient uses cane to ambulate. Posture is forward flexed. Range of motion: hip normal, knee normal, ankle normal, feet normal. Tenderness to palpation noted over hamstrings of bilateral lower extremities." [REDACTED] is requesting DME motorized scooter. The utilization review determination being challenged is dated 6/17/14. [REDACTED] is the requesting provider, and he provided treatment reports from 1/18/13 to 5/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME- 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 & Leg-Power mobility Device.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG guidelines, knee chapter, (<http://www.odg-twc.com/odgtwc/knee.htm#Walkingaids>) Walking aids (canes, crutches, braces, orthoses, & walkers) Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanics load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker.

Decision rationale: This patient presents with buttock pain and bilateral leg pain. The treater has asked for DME motorized scooter on 5/19/14. Regarding Power Mobility Devices, MTUS does not recommend 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 treater is requesting a motorized scooter, but physical examination revealed the patient is ambulating with

a cane. Furthermore, there is no documentation of upper extremity problems where a manual wheelchair cannot be considered. Recommendation is for denial.