

Case Number:	CM14-0071801		
Date Assigned:	07/16/2014	Date of Injury:	03/27/2012
Decision Date:	09/03/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/19/2014

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 & Rehab and is licensed to practice in Illinois. 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 59-year-old female who reported an injury on 03/27/2012. The mechanism of injury was noted to be a trip and fall onto both of her knees. Her diagnoses were noted to be osteoarthritis localized primarily involving the lower leg, lumbago, morbid obesity, and chronic pain syndrome. The injured worker's prior treatments were noted to be injections and medications. The injured worker had an MRI of the right knee. The injured worker denied prior surgeries. The injured worker had a clinical evaluation on 04/17/2014. The subjective complaints were noted to be pain in her knees. The objective physical exam findings were tenderness to palpation with patella crepitus of the right knee. Range of motion was decreased to 90 degrees bilaterally. The injured worker reported pain was relieved and she had improved function with her medications. The medications were not noted on the clinical evaluation. The treatment plan was for a custom ordered electronic scooter. The rationale for the request was provided within the treatment plan of the clinical evaluation dated 04/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric 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 Power mobility devices (PMDs), page(s) 99 Page(s): 99.

Decision rationale: The request for Electric scooter is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend a power mobility device if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or if the patient has sufficient upper extremity function to propel a manual wheelchair, or if there is a caregiver who is available, willing, and able to provide assistance with manual wheelchair. Early exercise, mobilization, and independence should be encouraged at all steps of the recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Based upon the clinical evaluation of a 04/17/2014 visit, it is not noted that the injured worker has a mobility deficit. Additional documentation would need to be provided to support the injured worker being immobile and unable to use a manual assistive device. Therefore, the request for Electric scooter is non-certified.