

Case Number:	CM14-0087309		
Date Assigned:	07/23/2014	Date of Injury:	10/20/2000
Decision Date:	08/29/2014	UR Denial Date:	05/31/2014
Priority:	Standard	Application Received:	06/11/2014

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 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 injured worker is a 75-year-old male who reported an injury on 10/20/2000. He is diagnosed with cervical and lumbar sprain/strain, frozen left shoulder, internal derangement of the bilateral knees, and plantar fasciitis of the bilateral feet. His past treatments were noted to include use of a back brace, use of a knee brace, and ambulation with a cane. It was noted that an MRI of the left knee on 10/17/2013 revealed a complex tear of the meniscus and an MRI of the lumbar spine performed on 02/24/2014 revealed disc bulging. On 05/12/2014, the patient was seen for follow up. It was noted that he had redness, swelling, and pain to his right foot caused by a reaction to antibiotic therapy. His symptoms were noted to include continued knee and back pain with limited mobility. His physical examination revealed limited range of motion in the left knee, difficulty with ambulation, and a sore on his foot. The treatment plan included postponing any surgical procedures due to his recent upper respiratory infections, elevated sedimentation rate, and elevated CRP. A recommendation was also made for a weight loss program, a scooter, and a lift for his vehicle. It was noted that a scooter was being recommended for ambulation due to his shortness of breath, back pain, and significant knee pain and the lift was recommended for his vehicle to transport the scooter. The request for authorization form was submitted on 05/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 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 (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & leg, Power mobility devices (PMDs).

Decision rationale: According to the Official Disability Guidelines, power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by use 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 able to provide assistance with a manual wheelchair. The clinical information submitted for review indicated that the injured worker was using a cane for ambulation but had shortness of breath and significant knee pain. However, his physical examination failed to provide evidence of motor deficits in the lower extremities to warrant use of a wheelchair. In addition, he was not shown to have decreased function in his upper extremities contraindicating use of a manual wheelchair. In addition, the documentation did not address whether he had a caregiver who could provide assistance with a manual wheelchair. In the absence of documentation addressing the criteria for powered mobility devices, and in the absence of clear motor strength deficits, the request is not supported. As such, the request is not medically necessary.

Prospective request for 1 lift for the injured worker's vehicle to transport scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary request is not medically necessary, none of the associated services are medically necessary