

Case Number:	CM15-0103946		
Date Assigned:	06/08/2015	Date of Injury:	07/24/2013
Decision Date:	07/13/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/29/2015

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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 female, who sustained an industrial injury on 7/24/13. The injured worker was diagnosed as having bilateral knee severe osteoarthritis, history of falls due to giving way of the knees and secondary compensatory back and hip complaints. Treatment to date has included arthroscopy of the left knee and medications. A report dated 12/13/14 noted the injured worker's knee range of motion was restricted and she had difficulty with ambulation. She was unable to kneel or squat and was experiencing pain, cracking, and crepitation in the knees. A report dated 4/25/15 noted the injured worker has been falling often and she is ambulating with a cane. Currently, the injured worker complains of bilateral knee problems, antalgic gait, back pain, and groin pain. The treating physician requested authorization for an electric scooter. The treating physician noted a scooter was recommended due to the injured worker's worsening symptoms and she is having more difficulty walking. Bilateral knee replacements were also recommended as part of the treatment plan. The medication listed is Percocet.

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back and Other Medical Treatment Guidelines CMS- Medicare.

Decision rationale: The CA MTUS and the ODG guidelines recommend that mobility assist devices can be utilized to improve physical function and independence in patients who are otherwise limited by decreased musculoskeletal function. The records indicate that the patient is currently ambulating with the use of a Cane. There is no documentation that utilization of a stable walker or manual wheelchair was not effective. The guidelines recommend that electric scooter be considered when there is lack of shoulder / upper extremity motor power or the absence of a willing help to propel a manual mobility assist devices. The documentation did not show that these conditions currently exist. The criteria for the use of electric scooter was not met. Therefore the request is not medically necessary.