

Case Number:	CM15-0108211		
Date Assigned:	06/12/2015	Date of Injury:	05/30/2012
Decision Date:	07/14/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/04/2015

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: California
 Certification(s)/Specialty: Orthopedic Surgery

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 57 year old female patient who sustained an industrial injury on 05/30/2012. The accident was described as while working normal duty as a health program specialist while she was walking into the work building she caught her foot on the edge of a tile in the entrance area that caused her to fall to her hands landing on her left hip. She needed assistance getting up and had immediate complaint of right hand pain, right knee, right shoulder and right hip pain. She was seen and treated with medication, ice, and modified work duty. She even received a Toradol injection. Physical therapy sessions have been helping the patient. She has been off from work since 07/03/2012. On 10/18/2012 she underwent a functional capacity evaluation. A computerized tomography scan done on 11/16/2012 showed there is a asymmetric left lateral disc space narrowing with vertebral sclerosis and endplate spurring at L3-4. This presumably accounts for the increased radiotracer uptake at the site on prior bone scan. There is dextrocolliosis; degenerative disc disease at L3-4 through L5-S1 and no more than mild spinal and foraminal stenosis. The same date of 11/16/2012 a chest computerized scan showed healed fracture deformity of the left third anterior rib near the costochondral junction. A primary treating office visit dated 10/18/2012 reported subjective complaint of having no significant changes in current symptoms. She states that her back and knee are sore form undergoing a recent QME evaluation and that most of her pain is located in the medial compartment and worse with activity. A MRI study was reviewed of the right knee showing a grade 3 tear of the medial meniscus, a small effusion noted. The following diagnosis was applied: derangement of posterior horn of medial meniscus right knee. The plan of care involved administration of an

intraarticular injection. A more recent follow up visit dated 03/10/2015 reported subjective chief complaint of neck pain, right shoulder, right hand, right hip, right knee, and back pain. The patient is pending a foot specialist appointment, follow up for knee with hopes of receiving an injection and follow up visit. Current medications are: MS Contin, Naproxen, Soma, Glucosamine, and Propranolol. Of note, she has tried Turmeric, Meloxicam, Naproxen, Norco, Percocet, and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric Scooter QTY: 3 (months): 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 and Leg Chapter, Power Mobility Devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cording to the ODG, Pain section, power mobility devices.

Decision rationale: CA MTUS/ACOEM is silent on the issue of a scooter. According to the ODG, Pain section, power mobility devices, "Not recommended 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 there is lack of evidence from the exam note of 3/10/15 of insufficient upper extremity function or inability to use a cane or walker. Therefore the determination is for non-certification. The request is not medically necessary.