

Case Number:	CM15-0168909		
Date Assigned:	09/09/2015	Date of Injury:	10/03/2011
Decision Date:	10/07/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/27/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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, who sustained an industrial injury on October 3, 2011. Currently, the injured worker reports increased right knee pain. A review of the medical records indicates that the injured worker is undergoing treatment for pain in the lower leg joint and knee pain. The Treating Physician's progress report, dated August 12, 2015, noted the injured worker rated her pain as 6 on a scale of 1 to 10 with medications, and 10 on a scale of 1 to 10 without medications, unchanged since the previous visit on July 8, 2015. The injured worker's activity level was noted to remain the same. The injured worker was noted to be using a walker and fell in the bathroom a few days previously with increased right knee pain. The injured worker was noted to be able to continue to walk with full range of motion (ROM). The physical examination was noted to show the injured worker was morbidly obese, with a right sided push off antalgic gait, assisted by a walker. The lumbar spine was noted to show range of motion (ROM) restricted, and paravertebral muscle spasm, tenderness, and tight muscle band bilaterally on palpation. Straight leg raise test was negative. The right knee was noted to have mild swelling, restricted range of motion (ROM), and tenderness to palpation over the medial joint line, without effusion. The injured worker deferred an x-ray of the right knee for evaluation. The injured worker was noted to request a wheelchair and motorized scooter as she could only walk 25 feet due to increased knee pain. The injured worker was noted to be medically retired. Prior treatments have included aquatic therapy, with the current medications of Omeprazole, Zipsor, Lidocaine ointment, Effexor, Neurontin, Norco, and Oxycontin. The request for authorization dated August 13, 2015, requested durable medical equipment (DME) of a wheelchair and a motorized scooter. The Utilization Review (UR) dated August 20, 2015, denied the request for a

wheelchair and a motorized scooter as neither was documented to be required for the injured worker's mobility.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Wheelchair QTY: 1.00: 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 (Acute and Chronic), Wheelchair.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wheelchair.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG recommends wheelchairs only when the injured worker has a disability that prevents other forms of assistance in ambulation. The provided medical records and physical exam do not meet these criteria and the request is not certified and therefore is not medically necessary.

DME: Motorized scooter QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: The California MTUS section on powered mobility devices states: 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. The patient does not meet criteria as cited above and the request is not certified and therefore is not medically necessary.