

Case Number:	CM15-0192159		
Date Assigned:	10/06/2015	Date of Injury:	02/07/1995
Decision Date:	11/13/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/29/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62 year old female who sustained an industrial injury on 2-7-1995. A review of the medical records indicates that the injured worker is undergoing treatment for knee pain, spinal-lumbar degenerative disc disease, degenerative spondylolisthesis and low back pain. According to the progress report dated 9-3-2015, the injured worker rated her pain with medications as 6 out of 10 and without medications as 8 out of 10. Her activity level had decreased. Per the treating physician (9-3-2015), the work status was permanent and stationary and the injured worker was not currently working. The physical exam (9-3-2015) revealed a slow, antalgic gait assisted by a walker. Bilateral knee range of motion was restricted by pain. There was tenderness to palpation over the right knee. There was tenderness to palpation over the left talo-fibular ligament. Treatment has included orthovisc injections and medications. Prescriptions (9-3-2015) included Roxicodone, Methadone, Norco and Ultram ER. The original Utilization Review (UR) (9-15-2015) denied requests for a motorized scooter and a lift.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized 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 (ODG).

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

Decision rationale: The patient rates his pain as 6/10 on VAS scale with medications although location of subjective pain is not noted in review of progress reports dated 2/5/15 to 9/3/15 provided by the treating physician; however, the patient has a diagnosis of knee pain and low back pain with exam findings showing tenderness to palpation over lateral/medial joint lines. The treater has asked for motorized scooter on 9/3/15. The request for authorization was not included in provided reports. The patient is s/p a decrease in activity level per 7/2/15 report. The patient is currently stable on current medication regimen, which has not changed in 6 months per 7/2/15 report. The patient is currently permanent and stationary and not working per 9/3/15 report. MTUS Guidelines, Power Mobility Devices Section, page 99 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 treater does not discuss this request in the reports provided. The patient does have knee pain. The patient has an antalgic and slowed gait, and is using assistive devices (a walker) as recently as 9/3/15 physical exam. The treater does not document the extent of mobility achieved with the help of the walker. MTUS supports the use of motorized scooters only if the immobility cannot be "sufficiently resolved by the prescription of a cane or walker." Given the lack of relevant documentation regarding the impact of the cane, the request for a motorized scooter cannot be substantiated. Therefore, the request is not medically necessary.

Lift: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [REDACTED] Clinical Policy Bulletin Number 0459.

Decision rationale: The patient rates his pain as 6/10 on VAS scale with medications although location of subjective pain is not noted in review of progress reports dated 2/5/15 to 9/3/15 provided by the treating physician; however, the patient has a diagnosis of knee pain and low back pain with exam findings showing tenderness to palpation over lateral/medial joint lines. The treater has asked for LIFT on 9/3/15. The request for authorization was not included in provided reports. The patient is s/p a decrease in activity level per 7/2/15 report. The patient is currently stable on current medication regimen, which has not changed in 6 months per 7/2/15 report. The patient is currently permanent and stationary and not working per 9/3/15 report. The ACOEM, MTUS and ODG Guidelines do not discuss chair lifts. [REDACTED] Clinical Policy Bulletin

Number 0459 under Seat Lifts and Patient Lifts, supports chair or patient lifts if the patient is incapable of standing from a seated position, has severe arthritis of the hip or knee, once standing must have ability to ambulate and seat lift must be prescribed to effect improvement, or to arrest or retard deterioration in patient's condition. [REDACTED] recommends lift chairs for patients that meet all criteria as stated above. The treater does not discuss this request in the reports provided. The patient currently ambulates with an antalgic/slowed gait, with assistance of a walker per requesting 9/3/15 report. In this case, the patient has ongoing knee pain with diagnoses of knee pain, spinal/lumbar DDD, spondylolisthesis degenerative, and low back pain per 9/3/15 report. The patient has a BMI of 31.17 per 9/3/15 report. However, there is no documentation of "severe arthritis of the hip or knee," as required by [REDACTED]. In addition, there is no discussion if the patient is able stand from a sitting position or able to ambulate once in a standing position. Therefore, the requested chair lift system IS NOT medically necessary.