

<b>Case Number:</b>	CM15-0210134		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	03/01/2006
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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:

The injured worker is a 65 year old female, who sustained an industrial injury on 3-1-2006. The medical records indicate that the injured worker is undergoing treatment for pain in lower leg joint, myalgia and myositis, knee, leg, ankle, and foot injury, and status post right total knee arthroplasty (2010). According to the progress report dated 9-11-2015, the injured worker presented with complaints of right knee pain. The pain is characterized as gnawing and sharp. On a subjective pain scale, she rates her pain 7 out of 10. The physical examination of the right knee reveals tenderness to palpation over the patella, plus one effusion, and painful and restricted range of motion. The current medications are Fentanyl, Benadryl, and Nortriptyline. Previous diagnostic studies include x-rays of the right knee. Treatments to date include medication management, ice, heat, physical therapy, continuous passive motion machine, femoral block, and surgical intervention. The treating physician stated that the "patient is still doing physical therapy-manipulation sessions; she is having increasing pain in the knee and increased trouble ambulating as a result of this manipulation". Work status is not indicated. The plan of care includes mobility scooter to support ambulation. The original utilization review (9-29-2015) had non-certified a request for mobility scooter.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Mobility Scooter:** Upheld

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

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

**Decision rationale:** The patient was injured on 03/01/06 and presents with right knee pain. The request is for a Mobility Scooter to support ambulation r/t increased pain and unsteadiness. The RFA is dated 09/22/15 and the patient's current work status is not provided. MTUS Chronic Pain Medical Treatment Guidelines, Power mobility devices (PMDs) 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 patient has tenderness to palpation over the patella of the right knee, plus one effusion, and a painful/restricted range of motion. She is diagnosed with pain in lower leg joint, myalgia and myositis, knee, leg, ankle, and foot injury, and status post right total knee arthroplasty (2010). Treatment to date includes medication management, ice, heat, physical therapy, continuous passive motion machine, femoral block, and surgical intervention. The 09/11/15 report states that the patient is having increasing pain in the knee and increased trouble ambulating as a result of her PT/manipulation sessions. Requesting mobility scooter to support ambulation; patient has fallen recently and is developing increasing physical signs of pain and misalignment related to difficulty in ambulation. The provider does not explain why the patient's ambulation difficulties cannot be overcome with a cane or a walker. There is no explanation as to why the patient would not be able to rely on wheel chair for long distance mobility. While this patient presents with a significant fall history, without demonstrated upper/lower extremity deficit, or a rationale as to why traditional assistive devices are insufficient for this patient, the requested motorized wheelchair cannot be substantiated. Therefore, the request is not medically necessary.