

<b>Case Number:</b>	CM15-0037884		
<b>Date Assigned:</b>	03/06/2015	<b>Date of Injury:</b>	08/01/2007
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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: 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 53-year-old female, who sustained an industrial injury on August 1, 2007. She has reported continued right knee pain, wrist pain, shoulder pain and right ankle pain. The diagnoses have included herniated lumbar disc with radiculopathy, left ankle strain, left foot strain, anxiety, depression, left knee medial meniscal tear, degenerative joint disease, status post right knee arthroscopy and partial thickness tear of the right rotator cuff. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the right knee, conservative therapies, pain medications and work restrictions. Currently, the IW complains of continued right knee pain, wrist pain, shoulder pain and right ankle pain. The injured worker reported an industrial injury in 2007, resulting in chronic right knee pain. She has been treated conservatively and surgically without resolution of the pain. Evaluation on July 30, 2014, revealed continued pain in the right knee, ankle, wrist and shoulder. It was noted she was attending physical therapy and required the use of pain medications. Evaluation on January 14, 2015, revealed continued pain. It was noted she experienced pain relief with previous acupuncture therapy. A motorized scooter, medications, additional acupuncture therapy and aqua therapy were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motor scooter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

**Decision rationale:** The patient presents with right knee pain, rated 6-7/10. The request is for MOTOR SCOOTER. Patient is status post right knee arthroscopy, date unspecified. Physical examination to the right knee on 01/14/15 revealed tenderness to palpation over the medial joint line. Range of motion was decreased and McMurray's test was positive. Patient's treatments have included physical therapy, aqua therapy and acupuncture treatments. Per 10/22/14, progress report, patient's diagnosis include herniated lumbar disc with radiculopathy. New injury September 5, 2011, left ankle strain, left foot strain, anxiety and depression, elevated blood pressure rule out hypertension secondary to pain, left knee medial meniscal tear, degenerative joint disease, status post right knee arthroscopy, partial - thickness tear of the right rotator cuff, right ankle pain and right wrist pain. Patient's medications per 01/14/15, progress report include Percocet, Prilosec, Ultram and Flexeril. Patient is permanent and stationary. Power Mobility Devices under MTUS pg 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. In 01/14/15, progress report, treater states that he recommends a motor scooter for support purpose. In the same report, patient states that the acupuncture treatment has helped relieve her pain. UR letter dated 02/16/15 states, "There is no documentation to support the inability to ambulate." In review of the medical records provided, there is no evidence that the patient is unable to ambulate with the aid of walker or a cane. There is no evidence of upper extremity problems or deficits to not be able to use a manual wheelchair if unable to ambulate. In this case, the guideline criteria for using a Motor Scooter are not met and therefore, the request IS NOT medically necessary.