

<b>Case Number:</b>	CM15-0082006		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	06/12/2011
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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:

The injured worker is a 59-year-old male, who sustained an industrial injury on 6/12/2011. He reported a fall down stairs. The injured worker was diagnosed as having knee pain, other repair of knee, and hip pain. Treatment to date has included diagnostics, multiple orthopedic surgeries, injections, transcutaneous electrical nerve stimulation unit, and medications. A minor cerebrovascular accident was noted in 2014 with residual effects not documented. Currently (3/18/2015), the injured worker complains of right hip and right knee pain, rated 5/10 with medication use and 7/10 without. His pain level and activity level decreased since prior visit. A steroid injection to his hip was noted on 3/04/2015. Medication use included Norco, Morphine sulfate IR, Rozerem, Aspirin, Atorvastatin, Cholecalciferol, Lisinopril, Metoprolol, and Xarelto. His gait was antalgic and assisted by a cane. Motor exam of the lower extremities revealed 5/5 strength bilaterally. With medication use he was able to stand for sixty minutes, walk for four blocks, and perform activities of daily living for 45 minutes at a time. His work status was permanent and stationary and he was not working. The rationale for the requested power scooter and car lift for power scooter was not noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Power mobility scooter:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

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

**Decision rationale:** Based on the 03/18/15 progress report provided by treating physician, the patient presents with right hip and right knee pain rated 5/10 with, and 7/10 without medications. Patient is status post right partial patellar resection and repair 06/17/05, right knee arthroscopy 08/21/09, and right total knee arthroplasty 09/15/10. The request is for power mobility scooter. Patient's diagnosis on 03/18/15 included knee pain, other repair of knee, and hip pain. The patient ambulates with assistance of cane, and has right sided antalgic, awkward and slowed gait. Physical examination to the right hip on 03/18/15 revealed tenderness over the sacroiliac joint and trochanter. Examination to the right knee revealed crepitation. Range of motion restricted and limited. Sensory examination revealed decreased light touch sensation over lateral calf and surgical scars on the right. Treatment to date has included diagnostics, multiple orthopedic surgeries, injections, TENS unit, and medications. Patient medications include Norco, Morphine, Rozerem, Atorvastin, Cholecalciferol, Lisinopril, Metoprolol, Xarelto and Aspirin. The patient is permanent and stationary, per 02/11/15 progress reports. Treatment reports were provided from 05/21/14 - 03/18/15. MTUS pg 99 under Power 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." Treater has not provided reason for the request. Progress report with the request, nor RFA were provided for review. MTUS allows for power mobility devices when cane, walker or manual wheelchair is not feasible due to upper extremity weakness and if there is no mobility with a cane or other assistive devices. Per 03/18/15 report, the patient is able to ambulate with a cane. According to guidelines, power mobility device would not be indicated. Therefore, the request is not medically necessary.

**Car lift for power scooter:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

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

**Decision rationale:** Based on the 03/18/15 progress report provided by treating physician, the patient presents with right hip and right knee pain rated 5/10 with, and 7/10 without medications. Patient is status post right partial patellar resection and repair 06/17/05, right knee arthroscopy 08/21/09, and right total knee arthroplasty 09/15/10. The request is for car lift for power scooter. Patient's diagnosis on 03/18/15 included knee pain, other repair of knee, and hip pain.

The patient ambulates with assistance of cane, and has right sided antalgic, awkward and slowed gait. Physical examination to the right hip on 03/18/15 revealed tenderness over the sacroiliac joint and trochanter. Examination to the right knee revealed crepitation. Range of motion restricted and limited. Sensory examination revealed decreased light touch sensation over lateral calf and surgical scars on the right. Treatment to date has included diagnostics, multiple orthopedic surgeries, injections, TENS unit, and medications. Patient medications include Norco, Morphine, Rozerem, Atorvastin, Cholecalciferol, Lisinopril, Metoprolol, Xarelto and Aspirin. The patient is permanent and stationary, per 02/11/15 progress reports. Treatment reports were provided from 05/21/14 - 03/18/15. MTUS pg 99 under Power 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." Treater has not provided reason for the request. Progress report with the request, nor RFA were provided for review. MTUS allows for power mobility devices when cane, walker or manual wheelchair is not feasible due to upper extremity weakness and if there is no mobility with a cane or other assistive devices. Per 03/18/15 report, the patient is able to ambulate with a cane. According to guidelines, power mobility device would not be indicated. Hence, a car lift for the scooter would not be indicated, either. Therefore, the request is not medically necessary.