

<b>Case Number:</b>	CM14-0183188		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	10/09/2009
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Allergy and Immunology and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 73-year-old male who reported an injury on 10/09/2009. The mechanism of injury was not specified. His diagnoses include right knee osteoarthritis. His past treatments include cold compresses, bracing, physical therapy, a home exercise program, a right knee steroid injection in 11/2009, and medication. The diagnostic studies include an x-ray of the right knee on 08/19/2014, which revealed moderate to severe medial compartment joint space narrowing with mild varus angulation. Additionally, there was mild to moderate patellofemoral joint space narrowing with marginal osteophytosis and small effusion. Relevant surgical history was not provided. On 10/02/2014, the injured worker reported restricted daily activity with functional limitations. The objective findings revealed right knee varus deformity and medial joint line tenderness. Current medications were noted to include Cozaar, Glyburide, Pioglitazone, Atenolol, Metformin, Simvastatin, Isosorbide Dinitrate, Hydrochlorothiazide, and aspirin. The treatment plan was noted to include obtaining x-ray imaging of the right knee with fluoroscopy. A request was received for a tow hitch assembly and a carrier platform for a scooter. A rationale was not provided. The Request for Authorization form was submitted for review on 10/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tow Hitch Assembly for Scooter:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**Decision rationale:** The request for tow hitch assembly for scooter is not medically necessary. The California MTUS Guidelines do not recommend power mobility devices if the patient has sufficient upper extremity function to propel a manual wheelchair. There was insufficient documentation to show the injured worker had objective functional deficits in his upper extremities that would preclude him from being able to propel a manual wheelchair. Additionally, there was insufficient documentation to show the injured worker owned or operated a scooter. Furthermore, there is insufficient documentation to justify a tow hitch assembly for a scooter. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for tow hitch assembly for scooter is not medically necessary.

**Carrier platform for scooter:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PDMs) Page(s): 99.

**Decision rationale:** The request for carrier platform for scooter is not medically necessary. The California MTUS Guidelines do not recommend a power mobility device if the patient has sufficient upper extremity function to propel a manual wheelchair. There was insufficient documentation to show the injured worker had objective functional deficits in his upper extremities that would preclude him from the ability to propel a manual wheelchair. Additionally, there was insufficient documentation that the injured worker owned or operated a scooter. Furthermore, there is insufficient documentation to justify a carrier platform for a scooter. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for carrier platform for scooter is not medically necessary.