

Case Number:	CM15-0015310		
Date Assigned:	02/03/2015	Date of Injury:	04/13/2003
Decision Date:	03/25/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/27/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 62-year-old female sustained work-related injury to her left shoulder, left cervical spine, left upper back and left arm on 4/13/2003. According to the progress notes dated 9/4/2014, the injured worker's (IW) diagnoses include chronic knee pain, chronic shoulder pain, chronic cervical pain, chronic thoracic myofascial pain and chronic lumbar back pain. She reports neck, upper back, bilateral shoulder, lower back and bilateral knee pain on 1/19/15 and Physical examination of the both knee revealed tenderness on palpation, swelling of the right knee and negative all special tests. Previous treatments include physical therapy, chiropractic and surgery. The medication list include Vicodin, Soma, Norco, Tylenol#3, Cymbalta, Darvocet and Lidoderm Patch. The patient's surgical history includes left shoulder surgery. The patient has used a cane, right ankle brace, a walker for this injury. Patient has received an unspecified number of weight loss program visits and pool therapy visits for this injury. Physical examination of the knee on 11/13/14 revealed tenderness on palpation on knee, swelling in knee, and negative all special tests. Physical examination of the lumbar spine revealed tenderness on palpation and limited range of motion. The past medical history include DM and right ankle fracture. The patient's surgical history includes TKR on right and partial knee replacement on left. As per records provided on 1/5/15 the scooter was examined by technician and its seat was damaged beyond repair and the scooter was hazardous to drive. She has had MRI of the lumbar spine on 03/13/2013 that revealed disc protrusion and foraminal narrowing.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Replacement 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, Knee & Leg (Acute & Chronic), Power Mobility Devices (PMDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Power mobility devices (PMDs). Decision based on Non-MTUS Citation ODG Treatment Integrated Treatment/Disability Duration Guidelines Knee & Leg (updated 02/27/15) Power mobility devices (PMDs)

Decision rationale: Request: Replacement scooter Per the CA MTUS chronic pain guidelines cited below, Power mobility devices are 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." Per the ODG cited below, power mobility devices are not recommended "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. (CMS, 2006) 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." Physical examination of the left and right knee revealed that all the special tests were negative. A detailed neurological exam demonstrating significant weakness of the upper and lower extremities or any other medical conditions that will compromise the patient's ability to ambulate by herself or with the help of a walker or cane, is not specified in the records provided. Significant functional deficits of the lower extremity that would require a scooter were not specified in the records. Rationale for the use of the knee scooter was not specified in the records provided. The absence of a care giver who can propel a manual wheel chair was not specified in the records provided. Inability of the patient to ambulate with canes or other assistive devices was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for 1 Replacement scooter is not fully established in this patient.