

Case Number:	CM15-0118270		
Date Assigned:	06/26/2015	Date of Injury:	05/23/2001
Decision Date:	07/27/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/18/2015

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: Arizona, 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:

The injured worker is a 63-year-old female who sustained an industrial injury on 5/23/2001 resulting in pain to the lower back and bilateral knees with reduced range of motion. The injured worker is diagnosed with lumbosacral sprain and bilateral knee strain, and subsequently, right knee chondromalacia and torn medial meniscus. Treatment has included right knee arthroscopic partial medial meniscotomy and chondroplasty patella, ice, heat, Synvisc injection, TENS unit, stabilization, and oral and transdermal pain medication. Effectiveness of these treatments is not presented in provided records. The injured worker is unable to ambulate for greater than ten minutes at a time and then experiences exacerbated pain, weakness and instability. The treating physician's plan of care includes aquatic therapy, medication, and purchase of a motorized scooter. She is presently not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hoveround chair to assist with ambulation: Overturned

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

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

Decision rationale: Powered Mobility Devices is 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. In this case, the claimant cannot maintain weight bearing and has brachial neuritis making it difficult to use the upper extremities with a walker, cane or manual wheelchair. The claimant was doing aqua therapy as a result of the instability. The request for a hove round/power wheelchair is appropriate and medically necessary.