

Case Number:	CM15-0098386		
Date Assigned:	06/01/2015	Date of Injury:	08/19/1998
Decision Date:	07/07/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	05/22/2015

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 57 year old female, who sustained an industrial injury on 8/19/98. The injured worker was diagnosed as having cervical spondylosis, cervical facet joint pain, bilateral shoulder impingement, bilateral carpal tunnel syndrome, bilateral DeQuervain's tenosynovitis, failed back surgery syndrome, lumbar radiculitis, and bilateral knee arthropathy. Treatment to date has included left knee arthroscopy on 10/10/14, 3 level lumbar spinal fusion, spinal cord stimulator implantation, chiropractic treatment, aqua therapy, physical therapy, cervical facet injections, and epidural injections. Currently, the injured worker complains of cervical spine pain radiating to bilateral upper extremities, bilateral shoulder pain, bilateral wrist pain, lumbar spine pain radiating to bilateral lower extremities, and bilateral knee pain. The treating physician requested authorization for a lightweight mobility scooter. The treating physician noted the injured worker was having significant difficulty in daily mobility, she is falling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lightweight Mobility Scooter QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic): Power Mobility Devices (PMDs).

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

Decision rationale: The patient presents with pain in cervical spine radiating to upper extremities, shoulders, wrists, lumbar spine radiating to lower extremities, and knees. The request is for lightweight mobility scooter qty 1. The request for authorization is dated 05/15/15. The patient is status-post three-level fusion in the lumbar spine, date unspecified. Left knee arthroscopy, 10/10/14. CT of the lumbar spine, 08/18/14, shows cage interbody spacer device noted at L5-S1 level; spinal canal and neural foramina are patent at all lumbar spine levels. X-ray of the left knee, 05/22/14, shows medial tibiofemoral osteoarthritis. X-ray of the right knee, 01/16/15, shows narrowing of both medial and lateral compartment consistent with arthritic change. X-ray of the right knee, 04/13/15, shows tricompartmental osteoarthritic change. CT of the right knee, 04/13/15, shows tricompartmental osteoarthritic change, most significant within the medial compartment; osteopenia. Physical examination of the cervical spine reveals bilateral facet joints are diffusely tender. Range of motion is 50% reduced with pain. Positive Spurling's test. Exam of upper extremities reveals bilateral upper trapezius, thomboid, teres, and periscapular muscles, acromioclavicular joints hypertonic and tender. Bilateral radiocarpal and ulnocarpal joints are tender; bilateral extensor pollicus longus and brevis tendons are tender. Impingement Sign, Painful Arc, and Apley's Scratch tests are positive. Exam of lumbar spine reveals range of motion 50% reduced with severe pain. Kemp's and Minor's Sign test are positive. Exam of lower extremities reveals bilateral lateral collateral and medial collateral ligaments are tender. McMurray's test is positive. Previous injection therapy has reportedly not been effective. The patient reports multiple falls due to loss of balance and loss of sensation in the left lower extremity. Patient's medications include Terocin and Omeprazole. Per progress report dated 05/01/15, the patient is temporarily totally disabled. 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." Per progress report dated 05/12/15, treater's reason for the request is "Patient is having significant difficulty in daily mobility; she is falling." However, there is no documentation of upper extremity issues where a cane, walker or manual wheelchair cannot be considered. MTUS allows for power mobility devices when cane, walker or manual wheelchair is not feasible due to upper extremity weakness. In this case, there is no indication that the patient does not have sufficient upper extremity function to use a cane, walker or manual wheelchair and that there is not a willing caregiver available for assistance. Therefore, the request is not medically necessary.