

Case Number:	CM13-0039695		
Date Assigned:	01/24/2014	Date of Injury:	06/29/2007
Decision Date:	05/20/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	10/08/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 56-year-old female who reported an injury on 06/29/2007. The mechanism of injury was not provided for review. The patient's treatment history included surgical intervention, psychological support, physical therapy, multiple medications, and activity modifications. The injured worker was evaluated on 08/23/2013. It was documented that the injured worker complained of pain radiating into the right upper extremity. No physical objective examination findings were provided at this evaluation. The injured worker's diagnoses included cervical spondylosis with myelopathy and complete rupture of the rotator cuff. The injured worker's treatment plan included electrodiagnostic studies, an orthopedic bed, and licensed acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 ORTHO BED: 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) and National Guidelines Clearinghouse

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Mattress, and Knee and Leg Chapter, Durable Medical Equipment (DME)

Decision rationale: The Expert Reviewer's decision rationale: The requested Ortho bed is not medically necessary or appropriate. California Medical Treatment and Utilization Schedule does not specifically address this request. Official Disability Guidelines do not recommend the use of 1 mattress over another. Additionally, Official Disability Guidelines, Knee and Leg Chapter, reference durable medical equipment as equipment that is not beneficial to the injured worker in the absence of physical limitations or injury. Official Disability Guidelines also state that durable medical equipment is generally rented versus purchased. As there is no indication that this is a request for a rental option and justification to support the need for an orthopedic bed over the injured worker's existing regular bed is not provided, the appropriateness of this request cannot be determined. As such, the requested Ortho bed is not medically necessary or appropriate.