

Case Number:	CM13-0067340		
Date Assigned:	01/03/2014	Date of Injury:	07/21/1997
Decision Date:	06/19/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/17/2013

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 and Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 53-year-old male who reported injury on 7/21/97. The injured worker's medication history included Trazodone as of August 2013. The mechanism of injury was not provided for review. The diagnoses include traumatic brain injury, obstructive sleep apnea, and headaches. The documentation of 8/15/13 revealed that the injured worker was performing occasional home gardening for exercise and to decrease anxiety. The injured worker was noted to be having worse difficulty sleeping due to cervical spine and mouth pain. The treatment plan included Trazodone 100mg at by mouth at bedtime as needed for sleep; yard work and walking; physical exercise; a gym membership; fissurectomy, sphincterotomy, and hemorrhoid surgery follow-up; continued home health; bathroom modifications; nurse case manager visits; continued psychotherapy; follow-up to receive an electric toothbrush; Oxygenal ozone treatment, mouthwash, and floss; an orthopedic bed; and medications. Subsequent documentation dated 11/13/13 revealed that the injured worker indicated that chewing makes pain worse, and his depression was worse with sleeping difficulty due to cervical spine and mouth pain. The treatment plan included the same recommendations along with a periodontal evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAZODONE 100MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT, KNEE & LEG AND LOW BACK ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 13.

Decision rationale: The California MTUS Guidelines recommend antidepressants as a first-line medication for the treatment of neuropathic pain. They are recommended especially if the pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective increase in function. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medications since August 2013. There was a lack of documentation of an objective increased ability to sleep. It was noted the injured worker's depression was worse and the injured worker had more difficulty sleeping due to cervical spine and mouth pain. The request as submitted failed to indicate the frequency and quantity for the requested prescription. Given the above, the request is not medically necessary.

GYM MEMBERSHIP: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, GYM MEMBERSHIPS

Decision rationale: The Official Disability Guidelines indicate that gym memberships are not recommended as a medical prescription unless a documented home exercise program with period assessment and revision has been ineffective, and there is a need for equipment. Gym memberships would not generally be considered medical treatment and therefore are not covered under the Official Disability Guidelines. The request as submitted failed to indicate the duration and the body part to be treated with the gym membership. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request is not medically necessary.

BATHROOM MODIFICATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE & LEG CHAPTER, DME

Decision rationale: The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable

medical equipment. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. 'Durable medical equipment' is defined as equipment which could be used repeatedly as in could normally be rented and used by successive patients, as primarily and customarily used to serve a medical purpose, and is generally not useful to a person in the absence of illness or injury. It should be appropriate for use in a patient's home. The clinical documentation submitted for review indicated the request was for bathroom modifications. However, the type of modifications were not noted. The request failed to indicate the type of modification that was being requested. The supplied documentation fails to meet the above criteria. Given the above, the request is not medically necessary.

ORTHOPEDIC BED: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 SELECTION, KNEE & LEG CHAPTER, DME

Decision rationale: The Official Disability Guidelines indicate that mattress selection is subjective and depends upon personal preference and individual factors. Mattresses are considered durable medical equipment. As such, the request must meet durable medical equipment guidelines. The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. 'Durable medical equipment' is defined as equipment which could be used repeatedly as in could normally be rented and used by successive patients, as primarily and customarily used to serve a medical purpose, and is generally not useful to a person in the absence of illness or injury. It should be appropriate for use in a patient's home. An orthopedic bed cannot be considered durable medical equipment, as it is useful to a person in the absence of illness or injury and it is not primarily and customarily used to serve a medical purpose. Given the above, the request is not medically necessary.