

Case Number:	CM14-0114271		
Date Assigned:	08/04/2014	Date of Injury:	02/10/2014
Decision Date:	09/10/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/22/2014

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 California. 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 patient is a 42 year old with an injury date on 2/10/14. Patient complains of lumbar pain that feels tight and that radiates to the right lower extremity without numbness, tingling, or weakness per 5/23/14 report. Patient is also wearing a lumbar brace, and complains of difficulty sleeping per 5/23/14 report. Based on the 5/23/14 progress report provided by [REDACTED] the diagnoses are: Tongue laceration - bit off portion of the tongue; Three fractured vertebrae; Broken hip; Broken hand; Sprained neck; Migraines; Broken fingers; Rule out: stroke, seizure, aneurysm. A 5/22/14 diagnosis adds: L3-4 anterior compression fracture. Exam on 5/23/14 showed mild difficulty transferring from chair to standing and from standing to the exam table and, normal muscle strength for the lower extremities. Lumbar range of motion is limited. [REDACTED] [REDACTED] is requesting continued hospital bed rental (low back) x 4 months and continue wheelchair rental (low back) x 3 months. The utilization review determination being challenged is dated 6/20/14 and denies the wheelchair due to lack of documentation that explains the medical necessity of the request. [REDACTED] is the requesting provider, and he provided treatment reports from 2/24/14 to 6/2/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue hospital bed rental (low back) x 4 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cigna Government services: Online ed., semi-electric bed. Clinical Policy Bulletin: Hospital Beds and Accessories, Number: 0543.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AETNA guidelines has the following regarding the use of hospital bed.

Decision rationale: This patient presents with back pain radiating to right leg and is status post right hand repair of second metacarpal comminuted base fracture from 3/13/14. The treater has asked for continued hospital bed rental (low back) x 4 months on 5/23/14. [REDACTED] stated he has no reason to order continued rental of the bed, and defers discussion to [REDACTED] per 5/23/14 report. The 6/2/14 report by [REDACTED] does not provide a useful discussion regarding the request. Aetna Clinical Policy Bulletin states a bed is medically necessary if patient's condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or the patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered; or the patient's condition requires special attachments (e.g., traction equipment) that cannot be fixed and used on an ordinary bed. In this case, patient has difficulty with transferring, but does not present with any condition that require positioning of the body, nor any respiratory conditions or any conditions that require special attachments that cannot be fixed on an ordinary bed. Recommendation is for denial.

Continue wheelchair rental (low back) x 3 months: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) has the following: Power mobility devices: Knee Chapter.

Decision rationale: This patient presents with back pain radiating to right leg and is status post right hand repair of second metacarpal comminuted base fracture from 3/13/14. The treater has asked for continue wheelchair rental (low back) x 3 months on 5/23/14. Regarding wheelchairs, ODG recommends if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. In this case, the patient has difficulty transferring, and the requested 3 month wheelchair rental appears reasonable for this type of condition. Recommendation is for authorization.