

<b>Case Number:</b>	CM14-0025790		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	07/07/2005
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine 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 52-year-old male with a reported date of injury on 07/07/2005. The mechanism of injury was noted to be by electrocution. His diagnosis was noted to include severe persistent somatic symptom disorder with predominant pain his previous treatment was medications. The injured worker complained of severe chronic pain in the neck, shoulders, low back, left knee, and right wrist. He also had feelings of being depressed, anxious, and angry. He had low self-esteem, headaches, and poor sleeping habit. The physical examination dated 03/31/2014 reported the injured worker presented with a slow gait and movements, expressed low mood, anger, and anxiety, and rated pain 7/10 to 9/10 without medications and 10/10 with moderate activity, but medication reduced his pain to 5/10 to 7/10 with rest and gentle short-term activity. The request for authorization form was not submitted within the medical records. The request is for a health back accent lift chair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HEALTH BACK ACCENT LIFT CHAIR:** 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).

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

**Decision rationale:** The request for health back accent left chair is not medically necessary. The injured worker is ambulatory with a slow gait and movements. The Official Disability Guidelines recommend durable medical equipment generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. The guidelines state medical conditions that result in physical limitations for injured workers may require education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The guidelines also state many assistive devices, such as electric garage door openers, microwave ovens, and golf carts were designed for the fully mobile, independent adult, and Medicare does not cover most of these items. There is a lack of documentation regarding previous conservative therapy or a home exercise program to assist the patient with his gait and movements. The guidelines do not specifically include lift chairs; however, the records do not establish objective evidence that the injured worker is unable to rise from a seated position without assistance. Therefore, the request is not medically necessary.