

Case Number:	CM14-0060012		
Date Assigned:	07/09/2014	Date of Injury:	12/31/2009
Decision Date:	08/26/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/30/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 female who reported an injury on 12/31/2009, the mechanism of injury was not provided. On 03/12/2014, the injured worker presented with low back pain radiating into the bilateral legs and an electrical sensation going from her back into her right leg and down her buttocks posterior into her feet. Upon examination of the lumbar spine, there was limited range of motion and tenderness in her upper thigh when reaching forward, and when she extends her back. There was bilateral paralumbar tenderness to palpation with tenderness along the lumbar vertebral process. The diagnoses were chronic low back pain and lumbar radiculopathy with neuropathic pain. Prior therapy included medications. The provider recommended an automatic adjustable hospital bed. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Automatic adjustable hospital 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), Knee & Leg, Durable Medical Equipment (DME).

Decision rationale: The request for an Automatic adjustable hospital bed is not medically necessary. Official Disability Guidelines state that if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment, a hospital bed would be recommended. Medical conditions that result in physical limitations for injured workers may require the injured worker's education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Durable medical equipment would be defined as the ability to withstand repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person in the absence of injury or illness, and appropriate for use in an injured worker's home. Since a hospital bed is not primarily or customarily used to serve a medical purpose, it would not be warranted. As such, the request is not medically necessary.