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| Case Number: | CM14-0137804 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 02/21/2011 |
| Decision Date: | 01/05/2015 | UR Denial Date: | 08/22/2014 |
| Priority: | Standard | Application Received: | 08/26/2014 |

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 Family Medicine and is licensed to practice in North Carolina. 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 40 year-old with a reported date of injury of 02/21/11 that occurred when the patient tripped over a box at work. The patient has the diagnoses of thoracolumbar sprain, lumbosacral strain, neck sprain, right shoulder sprain and left knee sprain. Past treatment modalities have included massage, acupuncture, aquatic therapy, physical therapy and trigger point injection. Per the progress report by the requesting physician dated 08/07/2014, the patient had complaints of unstable knee and shoulder pain. The physical exam noted the patient to be lying on the right side in a curled position. There was noted tenderness in the right upper back and neck and shoulder, lumbosacral muscles with spasm. Both legs had noticeable atrophy and there was pain in the left knee with flexion along with crepitus. Treatment recommendations included repeat trigger point injection, request for a motorized wheel chair, request for a hospital bed and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Hospital 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), Low Back Chapter, Mattress Selection.

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 Pain, Mattress Selection.

Decision rationale: The ACOEM and the California MTUS do not specifically address a hospital bed. The ODG does discuss mattress selection in the low back chapter. The ODG states "There are no high-quality studies to support the purchase of any specialized mattress or bedding as a treatment for low back pain." The requesting physician states the reason for the bed is to assure adequate comfort and positioning and to reduce the patient's risk for bedsores and aggravating the patient's back pain. The ODG does states that specialized mattresses designed to redistribute pressure may be used to treat pressure ulcers in the case of spinal cord injury. There is no indication from the physical exam that his patient has pressure ulcers. There is also no indication from the patient's diagnose as to why this patient would be bed bound and prone to pressure ulcers. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

Motorized Wheelchair: 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), Knee and Leg Chapter, Wheelchair.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

Decision rationale: The California MTUS states that powered mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or a walker or if the patient has sufficient upper extremity function to propel a manual wheelchair. While the provided documentation odes mention lower extremity atrophy, there is no documentation in the physical exams that would note a lack of upper extremity function that would limit the patent's ability to use a manual wheel chair. Therefore, the request the request is not medically necessary.