

Case Number:	CM14-0196036		
Date Assigned:	12/04/2014	Date of Injury:	04/07/2012
Decision Date:	01/21/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/24/2014

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 Interventional Spine 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 52-year-old female with date of injury of 04/07/2012. The list of diagnoses from 05/15/2014 are: 1. Left shoulder pain, 2. Predominantly of right-sided low back pain, 3. Weakness of the left upper extremity and right lower limb, 4. Myofascial pain, 5. Sleep disorder, 6. Mild to moderate depression following industrial injury. According to this report the patient complains of left shoulder pain that radiates down to her lower back into the right side. She has utilized gabapentin and cyclobenzaprine. The patient's gait is markedly antalgic. She is unable to walk on her heels or toes due to significant pain. Cervical range of motion is decreased. There is significant weakness and sensory deficits on the left upper extremity. Straight leg raise is positive on the right. Treatment reports from 05/08/2014 to 10/08/2014 were provided for review. The utilization review denied the request on 10/30/2014. They were all requested for the same reason, the treater says, "The patient has been trained on the prescribed equipment and has demonstrated competency in performing a home exercise program requiring this equipment."

IMR ISSUES, DECISIONS AND RATIONALES

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

Wedge Cushion: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 47.

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 Chapter on Durable Medical Equipment

Decision rationale: This patient presents with low back and left shoulder pain. The treater is requesting a WEDGE CUSHION. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines for durable medical equipment states that it is generally recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). DME is an equipment that can withstand repeated use; primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of illness or injury; is appropriate for use in the patient's home. The 10/06/2014 FRP report notes, "The patient has been trained on the prescribed equipment and has demonstrated competency in performing a home exercise program requiring this equipment." The treater does not discuss the exact use of this equipment. Furthermore, Labor Code 4610.5(2) definition of medical necessity. ""Medically necessary" and "medical necessity" meaning medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury..." In this case, the requested wedge cushion does not meet ODG's guidelines for durable medical equipment. The request IS NOT medically necessary.

Occipital Float: 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 Chapter on Durable Medical Equipment

Decision rationale: This patient presents with low back and left shoulder pain. The treater is requesting OCCIPITAL FLOAT. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines for exercise equipment refers to durable medical equipment, which states that it is generally recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). DME is an equipment that can withstand repeated use; primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of illness or injury; is appropriate for use in a patient's home. ODG also does not differentiate one type of exercise over another. In this case, there is no discussion as to why this equipment is necessary in performing her home exercise program. Furthermore, Labor Code 4610.5(2) definition of medical necessity. ""Medically necessary" and "medical necessity" meaning medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury..." Given that the requested occipital float does not meet ODG's criteria for DME, the request IS NOT medically necessary.

BOSU Ball: 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), Shoulder chapter: Gym Memberships

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 Chapter on Durable Medical Equipment

Decision rationale: This patient presents with low back and left shoulder pain. The treater is requesting BOSU BALL. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines for exercise equipment refers to durable medical equipment, which states that it is generally recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). DME is an equipment that can withstand repeated use; primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of illness or injury; is appropriate for use in a patient's home. ODG also does not differentiate one type of exercise over another. In this case, there is no discussion as to why this equipment is necessary in performing her home exercise program. Furthermore, Labor Code 4610.5(2) definition of medical necessity. ""Medically necessary" and "medical necessity" meaning medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury..." Given that the requested BOSU ball does not meet ODG's criteria for DME, the request IS NOT medically necessary.