

Case Number:	CM14-0199682		
Date Assigned:	12/10/2014	Date of Injury:	06/06/2002
Decision Date:	01/27/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/01/2014

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 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 injured worker is a 73 year old male with a date of injury of June 6, 2002. Results of the injury include low back pain, right knee pain, and neck pain. Diagnosis include chronic low back pain s/p decompressive surgery at L3-L4 and L4-L5, chronic right knee pain post total knee replacement, weak vocal cords with raspy voice following his right total knee replacement, chronic neck pain history of multilevel spinal fusion, chronic right shoulder pain, and chronic left shoulder pain. Treatment has included surgery and Tylenol # 4 for pain. Magnetic resonance imaging scan of the lower back revealed severe spinal stenosis. Magnetic resonance imaging scan of the neck showed fusion at C4-C5, C5-C6, and C6-C7, spondylolisthesis greater than 50 % at C7-T1 which has increased since the previous study, degeneration at C3-C4. The spinal cord was not enlarged or cavitated. Magnetic resonance imaging of the lumbar showed severe multilevel degenerative disease and scoliosis convexing to the right, sever canal stenosis at L4-L5 grade 1 spondylolisthesis and bilateral foraminal narrowing. Magnetic resonance imaging of the right shoulder showed there is a prior rotator cuff tear arthropathy with chronic complete tears at the supraspinatus infraspinatus and subscapularis tendons. Progress report dated November 13, 2014 showed the injured worker to be wheelchair bound and continues to use a computed generating speaking device. The injured worker was noted as retired. Treatment plan included Tylenol # 4, request for home care, and specific equipment for needs. The note goes on to state that the patient needs a "cage over his bed with device to help pull himself up and maneuver in bed." The treatment plan requests a "in-home ergonomic evaluation to evaluate what he needs for assistance to transition in the bathroom as well as over his hospital bed that was authorized." A letter dated December 15, 2014 posits a question as to "whether it would be more appropriate and safer, and be more consistent with the standard of care, for the patient to be discharged to a custodial care facility rather than to the home setting given the frail miss of the

patient's medical condition." Utilization review form dated November 4, 2014 noncertified a Hospital Bed for the Home due to noncompliance with Official Disability Guideline criteria.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hospital Bed for Home: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, DME, Knee

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 (DME)

Decision rationale: Regarding the request for a 3-in-1 commode (purchase), California MTUS does not address the issue. ODG states certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Within the documentation available for review, the requesting physician indicates that a hospital bed "was authorized." It appears, therefore, that this is a redundant requests. If it is not, the requesting physician has recommended an in-home ergonomic evaluation to assess the patient's needs. Additionally, he does not seem clear as to whether the patient will be able to continue in-home care, or need to transition to a custodial care facility. It seems reasonable to await the outcome of the in-home ergonomic evaluation and allow the physician to determine the patient's future disposition, prior to the purchase of an in-home hospital bed. As such, the currently hospital bed is not medically necessary.