

Case Number:	CM15-0007743		
Date Assigned:	01/26/2015	Date of Injury:	10/01/1993
Decision Date:	03/26/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 61-year-old male who reported an injury on 08/01/1994 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his low back that ultimately resulted in fusion surgery. The injured worker developed intractable postsurgical chronic low back pain. The injured worker was evaluated on 02/02/2015. It was documented that the injured worker had continued neck and low back pain complaints. The injured worker complained of 10/10 pain with and without medications. It was noted that the injured worker had ongoing limitations in participation of activities of daily living due to pain. Examination of the lumbar spine documented tenderness and spasming to the bilateral paraspinous musculature with restricted range of motion secondary to pain and decreased sensitivity in the L4-S1 dermatomal distribution and positive straight leg raising tests bilaterally. Evaluation of the upper extremities noted bilateral tenderness with range of motion within normal limits. The injured worker had tenderness to palpation of the bilateral groin area. The injured worker's diagnosed included lumbar disc degeneration, chronic pain, lumbar postlaminectomy syndrome, lumbar radiculopathy, status post thoracic spine desiccation, T7-8 compression fracture, positive foot drop, bilateral shoulder pain, depression, and erectile dysfunction due to pain. The injured worker's treatment plan included home care assistance due to functional limitations in the injured worker's activities of daily living. An orthopedic bed was also recommended to facilitate positioning for improved sleep quality. A Request for Authorization form was submitted on 02/02/2015 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continuation of home care assistance for 6 hours per day for 5 days per week for 6 months:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health. Page(s): 51.

Decision rationale: Continuation of home care assistance for 6 hours per day for 5 days per week for 6 months is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends home health care assistance for injured workers who are home bound on a part time or intermittent basis. The clinical documentation does indicate that the injured worker was previously approved for home care assistance. However, there was no documentation that the injured worker is currently home bound for any period of time during the day. Additionally, the clinical documentation does not specifically identify any medical conditions that would require the assistance of a nurse. As such, the requested continuation of home care assistance for 6 hours per day for 5 days per week for 6 months is not medically necessary or appropriate.

Orthopedic bed with generic mattress: 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), Pain Chapter, DME

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Mattress.

Decision rationale: The requested orthopedic bed with generic mattress is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not specifically address this request. The Official Disability Guidelines do not support the use of any specific type of mattress or type of bed to treat low back pain. The clinical documentation submitted for review does not provide any evidence that the injured worker would benefit from an orthopedic bed and that it would serve a medical purpose over a regular type of bed. As such, the requested orthopedic bed with generic mattress is not medically necessary or appropriate.