

Case Number:	CM15-0132533		
Date Assigned:	07/16/2015	Date of Injury:	01/30/2002
Decision Date:	10/05/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/06/2015

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: Preventive Medicine, Occupational Medicine

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 85 year old female who sustained an industrial /work injury on 1/30/02. She reported an initial complaint of right hip pain. The injured worker was diagnosed as having s/p hip replacement, mononeuritis of right lower extremity, right calf pain and venous irritation, muscle imbalance. Treatment to date includes medication, diagnostics, and surgery. Currently, the injured worker complained of mobility and fatigue along with right lower extremity/calf pain. Per the primary physician's report (PR-2) on 4/28/15, exam revealed swelling in the right ankle, use of a walker and wheelchair for mobility, and decreased range of motion in the hip. On 6/2/15, there were complaints of right calf pain for 24 hours. Examination revealed right calf tenderness. Current plan of care included resume lower extremity muscle strengthening. The requested treatments include hospital Electric Bed-Cloud/ Maxi Comfort (DOS 06/24/2014), Half Rail Clamp-On (DOS 07/24/2014, Cervical Contour Pillow (DOS 07/24/2014), Lift Chair (DOS 06/24/2014), Classic Mattress (DOS 06/03/2014), Classic Mattress Pad (DOS 06/03/2014), and Jobst Active Wear x 4 pair (DOS 12/28/2014).

IMR ISSUES, DECISIONS AND RATIONALES

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

Hospital Electric Bed-Cloud/ Maxi Comfort (DOS 06/24/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aerna.com/cpb/medical/data/500_599/0543.html.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Clinical UM Guideline, 10/08/2013; Hospital Beds and Accessories.

Decision rationale: The MTUS is silent on this issue. A fixed height hospital bed is considered medically necessary if one or more of the following criteria are met: 1. The individual has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain, prevent contractures, promote good body alignment or avoid respiratory infections. 2. The individual requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed. 3. The individual requires special attachments, such as traction equipment, that can only be attached to a hospital bed. There is no evidence in the medical record that any of the above criteria are met. Hospital Electric Bed-Cloud/ Maxi Comfort (DOS 06/24/2014) is not medically necessary.

Half Rail Clamp-On (DOS 07/24/2014): 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 Blue Cross of California Clinical UM Guideline, 10/08/2013; Hospital Beds and Accessories.

Decision rationale: The MTUS is silent on this issue. A fixed height hospital bed is considered medically necessary if one or more of the following criteria are met: 1. The individual has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain, prevent contractures, promote good body alignment or avoid respiratory infections. 2. The individual requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed. 3. The individual requires special attachments, such as traction equipment, that can only be attached to a hospital bed. There is no evidence in the medical record that any of the above criteria are met. Half Rail Clamp-On is not medically necessary.

Cervical Contour Pillow (DOS 07/24/2014): 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) Neck and Upper Back Chapter, Pillow.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Pillow.

Decision rationale: The Official Disability Guidelines recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. Cervical Contour Pillow is not medically necessary.

Lift Chair (DOS 06/24/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.cigna.com/customer_care/healthcase/professional/coverage/positions/medical/mm_0343_coveragepositionacriteria_seat_lift_mechanism_patient_lift.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

Decision rationale: According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Lift Chair is not medically necessary.

Classic Mattress (DOS 06/03/2014): 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) Regarding Mattress Selection, Low Back.

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 & Lumbar & Thoracic (Acute & Chronic), Mattress selection.

Decision rationale: The Official Disability Guidelines state that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back and hip pain. Mattress selection is subjective and depends on personal preference and individual factors. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Classic Mattress is not medically necessary.

Classic Mattress Pad (DOS 06/03/2014): 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 Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

Decision rationale: According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Classic Mattress Pad is not medically necessary.

Jobst Active Wear x 4 pair (DOS 12/28/2014): 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 Regarding Compression Garments.

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 (Acute & Chronic), Compression garments.

Decision rationale: The Official Disability Guidelines state that initially there was evidence to support the use of compression, but questions remained regarding dosimetry, length of time, and level of compression. A 2014 study, Kahn, does not support the routine wearing of elastic compression stockings. Jobst Active Wear x 4 pair (DOS 12/28/2014) are not medically necessary.

