MAXIMUS Federal Services

Case Number:	CM15-0137423		
Date Assigned:	07/27/2015	Date of Injury:	04/21/2009
Decision Date:	08/31/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/15/2015

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: Pennsylvania
Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 60 year old female who sustained an industrial injury on 4/21/09 from a trip and fall where she landed on her right buttocks. She was medically evaluated and eventually was recommended to have a right hip replacement which was done in 3.2012 and was successful. In 12.2012 she had her left hip replaced but with no significant pain relief. She had prior work related complaints from 2006 involving her bilateral upper extremities and neck brought on by work activities. She currently complains of back right hip, knee and ankle pain. The back pain and stiffness goes through her legs. On physical exam there was trigger points palpable in the gluteus medius region, lumbar quadratus region bilaterally; tenderness along the biceps tendon and acromioclavicular joint; positive crepitus with passive range of motion of the knee, shoulder; positive McMurray's test bilaterally. She has sleep difficulties regarding getting and staying asleep (per 5.12.15 note). She uses a cane for ambulation. Medication was oxycodone. Diagnoses include complex regional pain syndrome of the left lower extremity; status post bilateral total hip replacement; sacroiliac joint dysfunction; chronic non-specific low back pain; gait instability; chronic pain syndrome; mood adjustment disorder. Treatments to date include medications; physical therapy which was helpful; aquatic therapy which was helpful. Diagnostics include MRI of the right knee (1.30.15) showing degeneration and tearing in both menisci, enthesopathy. In the progress note dated 5.12.15 the treating provider's plan of care included requests for an orthopedic bed where she can adjust the bed to take the stress off her spine, hip and pelvic area; a motorized scooter for community ambulation to maximize her functional independence for getting around town, shopping and overall self-care needs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs) Page(s): 99. Decision based on Non-MTUS Citation Hoenig H, et al. Overview of geriatric rehabilitation: Program components and settings for rehabilitation. Topic 16852, version 10.0. UpToDate. Accessed 08/29/2015.

Decision rationale: Mobility devices may be used for physical limitations affecting mobility, such as weakness, problems with balance, limited endurance, and/or sensory issues. Devices are intended to improve mobility and independence and to provide some protection against falls. However, there is limited research on the impact of these devices. Wheelchairs are needed when a person is unable to have weight on the legs or has a significant limitation with function. Some examples of a significant limitation include severe weakness in both legs or balance and coordination problems that are so severe a walker cannot be used. The MTUS Guidelines support the use of motorized devices when a cane or walker is not sufficiently helpful, the worker does not have the arm strength to independently use a wheelchair, and a caregiver is not available to help the worker move the wheelchair. Motorized devices should only be used if absolutely necessary for mobility. The submitted and reviewed documentation indicated the worker was experiencing back pain with stiffness and weakness that went into the legs; pain in the right hip, knee, and ankle; decreased sleep; problems with concentration and memory; and mood difficulties. The worker was able to walk with a cane for of a block before stopping due to pain. These records did not describe any of the above situations or describe special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a motorized scooter is not medically necessary.

Orthopedic 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, Treatment in Workers' Compensation, Work Loss Data Institute, Low Back, Lumbar and Thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chou R, et al. Subacute and chronic low back pain: Pharmacologic and non-interventional treatment. Topic 7770, version 31.0. UpToDate, accessed on 08/28/2015.Schutte-Rodin S, et al. Clinical guideline for the evaluation and management of chronic insomnia in adults. J Clin Sleep Med. Oct 15 2008; 4(5): 487-504. (American Academy of Sleep Medicine (AASM) Guideline).National coverage determination for hospital beds. Centers for Medicare and Medicaid Services. Accessed 08/28/2015. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=227&ncdver=1&bc=AAAAQAAAAAAA&.

Decision rationale: The MTUS Guidelines are silent on this issue in this clinical situation. There are many conservative treatments that can improve lower back pain intensity and a worker's overall function. There is some literature to support the use of medium-firm mattresses

over firm mattresses and conforming-type mattresses over firm mattresses to minimize pain and pain-related sleep loss. These terms are subjective, however, and may vary in meaning. An electronic bed adjustment feature is needed when the worker requires changes in positioning immediately or quite frequently, and the worker is able to operate the controls. The 2008 AASM Guideline and the literature stress the importance of a thorough history in order to establish the type and evolution of insomnia, perpetuating factors, and pertinent concurrent issues. Monitoring data from a sleep diary before and during active treatment is strongly encouraged. The submitted and reviewed records indicated the worker was experiencing on-going lower back pain. There was no discussion detailing the reason proper positioning and body support could not be achieved in a regular bed or sufficiently supporting the need for a special mattress. A detailed assessment of the worker's sleep problem was not documented. There was no discussion detailing the reason proper positioning could not be achieved in a regular bed or a need for frequent or immediate position changes requiring electronic controls. In the absence of such evidence, the current request for an orthopedic bed is not medically necessary.