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| Case Number: | CM15-0137526 | | |
| Date Assigned: | 07/27/2015 | Date of Injury: | 03/02/2013 |
| Decision Date: | 08/31/2015 | UR Denial Date: | 06/17/2015 |
| 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: 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 40 year old male who sustained an industrial injury on 03-02-13. Initial complaints and diagnoses are not available. Treatments to date include medications and physical therapy. Diagnostic studies include a MRI of the left wrist. Current complaints include neck pain radiating down his arms. Current diagnoses include bilateral plantar fasciitis, degenerative lumbar disc, bilateral medial and lateral epicondylitis, bilateral forearm extensor tendon tendinitis, chronic bilateral wrist strain and sprain, chronic cervical and thoracic strain, cervical and thoracic central disc protrusion, ganglion left palm and long finger, left cubital tunnel syndrome, insomnia, and left cervical radiculopathy. In a progress note dated 06-01-15 the treating provider reports the plan of care as a consultation with a upper extremity surgeon in network, a psychiatrist or psychologist, as well as pain management, as well as a hospital bed and recliner to address the injured worker's difficulty sleeping. The requested treatments include a hospital bed and recliner.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hospital Bed for neck, upper mid back and bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back - Bed rest.

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. The hospital bed is not medically necessary.

Recliner for neck, upper and mid back and bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Bed rest.

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. Recliner for neck, upper and mid back and bilateral upper extremities is not medically necessary.

