

Case Number:	CM15-0187948		
Date Assigned:	09/29/2015	Date of Injury:	03/14/2014
Decision Date:	11/09/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/24/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 54 year old female, who sustained an industrial injury on 03-14-2014. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for bilateral upper extremity tendinitis, bilateral carpal tunnel syndrome, cervicothoracic strain, cervical radiculopathy, left shoulder impingement syndrome. Medical records (to 09-03-2015) indicate ongoing neck pain with radiation to both upper extremities (left greater than right) including pain in the shoulders, elbows, wrist and hands, and anterior pectoral pain. Pain levels were 9 out of 10 on a visual analog scale (VAS). Shoulder pain was reported to be worse with lying flat. Cervical pain is alleviated with sitting up (has had to sleep in an upright position for over a year) with reported disturbed sleep (up to 3-4 hours per night). Records also indicate the IW has had several falls at home trying to navigate stairs, has difficulty driving, overhead lifting, bending, and sitting for long periods. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exam, dated 09-03-2015, revealed an appearance of moderate distress, tenderness to the dorsal and volar sides of the bilateral upper extremities, increased tenderness at the end of flexion and extension of the wrists, severe left shoulder impingement, subacromial space tenderness, positive Apley scratch, positive obturator, and continued bilateral cervical muscle tenderness and thoracic muscle tenderness. Relevant treatments have included: bilateral carpal tunnel releases, left rotator cuff repair, cortisone injections, physical therapy (PT), work restrictions, and pain medications. The treatment plan included continued medications and use of splints, Sleep Number bed to aide with cervicothoracic strain, and follow-up. The request for authorization (09-09-2015) shows that the following equipment was requested: one Sleep Number bed. The original utilization review (09-15-2015) non-certified the request for one Sleep Number bed based.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 sleep number 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, Low back-lumbar and thoracic (Acute and Chronic) Mattress selection.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The requested DME does not serve a purpose that cannot be accomplished without it. The prescribed equipment does not meet the standards of DME per the ODG. The ODG and ACOEM also do not support the use of a mattress in the treatment of pain. Therefore the request is not medically necessary.