

<b>Case Number:</b>	CM15-0194946		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	12/27/1995
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 62 year old male, who sustained an industrial injury on 12-27-1995. He has reported injury to the low back. The diagnoses have included low back pain; and failed back surgery. Treatment to date has included medications, diagnostics, intrathecal pump placement, and surgical intervention. Medications have included Motrin, Vicodin, and intrathecal medications to include Fentanyl, Bupivacaine, Dilaudid, and Clonidine. A progress report from the treating provider, dated 09-08-2015, documented an evaluation with the injured worker. The injured worker reported low back pain rated at 4 out of 10 in intensity; the pain is described as constant, sharp, and pressure; the pain increases with motion; pain is decreased compared to previous visit; he is "doing well after catheter revision"; the intrathecal pump is working "very well" to maintain pain control; his pain is markedly improved with the intrathecal medications; and he reports improved activities of daily living. Objective findings included he appears in no acute distress; he is alert and oriented; there are well-healed incisions at the right and left upper abdominal quadrants; he walks with crutches, slow gait; low back pain is associated with movement; he rises from the chair with moderate antalgic guarding and hesitancy; stands with markedly forward stooped posture; pronounced sensitivity to palpation in the lumbar spine midline; hyperalgesia and pain on palpation at the midline upper lumbar spine; and generalized weakness, guarding, and hesitancy in ambulation and movement. The treatment plan has included the request for hospital type bed (indefinite use) x1. The original utilization review, dated 09-17-2015, non-certified the request for hospital type bed (indefinite use) x1.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hospital type bed (indefinite use) x1:** 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) 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 back pain. The patient also does not have documented significant weaknesses or deficits requiring a hospital bed. Therefore the request is not medically necessary.