

Case Number:	CM15-0196352		
Date Assigned:	10/12/2015	Date of Injury:	08/01/2012
Decision Date:	12/18/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/06/2015

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 56-year-old male, who sustained an industrial injury on 08-01-2012. He has reported injury to the bilateral knees and low back. The diagnoses have included lumbar sprain-strain; lumbar disc disease; lumbar spondylosis; cervical spondylosis; myofasciitis, cervical and lumbar spine; and bilateral knee arthritis. Treatments have included medications, diagnostics, heat, cold, aquatic therapy, physical therapy, and lumbar epidural steroid injection. Medications have included Norco, MS Contin, Relafen, and Gabapentin. A progress note from the treating physician, dated 09-02-2015, documented an evaluation with the injured worker. The injured worker reported he had an epidural injection since his last visit; he had a pacemaker put in on 08-26-2015 due to low heart rate; he has constant neck pain; there is painful and restricted movement of his neck; there is radiant pain to the arms; constant pain in the right shoulder; he has painful and limited movement of the shoulder joint; the low back pain is constant; painful and reduced mobility of his back; there is radiating pain to the legs, associated with numbness and tingling of the left leg; and he has constant pain to the right knee. Objective findings included tenderness to palpation over the left C5-6 and C6-7 region; painful and limited range of motion; sensory exam reveals decreased sensation to light touch over the entire right palm and all digits; and lumbar spine tenderness to palpation over the bilateral L5-S12. The treatment plan has included the request for shower chair; home care assessment; therapeutic king size bed; and orthopedic shoes with inserts. The original utilization review, dated 09-25-2015, non-certified the request for shower chair; home care assessment; therapeutic king size bed; and orthopedic shoes with inserts.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shower chair: 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 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; 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; 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. Shower chair is not medically necessary.

Home care assessment: 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Home Health Services.

Decision rationale: The Official Disability Guidelines recommend home health services only for recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The medical record does not contain documentation that the patient requires medical services to be provided at the home. Home care assessment is not medically necessary.

Therapeutic king size bed: 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 Official Disability Guidelines (ODG) Mattress selection Low Back - Lumbar & Thoracic (Acute & Chronic).

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 pain. Mattress selection is subjective and depends on personal preference and individual factors. Therefore, this request is not medically reasonable at this time. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Therapeutic king size bed is not medically necessary.

Orthopedic shoes with inserts: 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 Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic), Shoes.

Decision rationale: The Official Disability Guidelines recommend heel pads and insoles for ankle conditions and various types of footwear for knee arthritis. Official Disability Guidelines also recommend orthotic devices for plantar fasciitis and for foot pain in rheumatoid arthritis. Custom-made shoes are not supported by the ODG for knee or low back conditions. Orthopedic shoes with inserts are not medically necessary.