

<b>Case Number:</b>	CM15-0202243		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	02/15/2011
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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, 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(n) 58 year old female, who sustained an industrial injury on 2-15-11. The injured worker was diagnosed as having L4-L5 and L5-S1 spondylolisthesis and stenosis with bilateral leg radiculopathy. Subjective findings (7-2-15, 8-6-15, and 9-3-15) indicated 5-7 out of 10 pain in the lower back with medications and 8-9 out of 10 pain without medications. The injured worker reported that the pain is worse in the morning. Objective findings (7-2-15, 8-6-15, and 9-3-15) revealed lumbar facet tenderness at L4-S1 and asymmetric loss of range of motion. As of the PR2 dated 9-17-15, the injured worker reports cervical and lumbar pain. She rates her pain 7-9 out of 10. The treating physician noted that the injured worker is not currently working. Objective findings include lumbar tenderness over the midline, asymmetric loss of range of motion and decreased sensation in the L5 nerve root distribution. The treating physician recommended lumbar surgery. There is no documentation noting the injured worker's available assistance at home or difficulty leaving the home for appointments. Treatment to date has included physical therapy, a TENS unit, Flexeril, Fentanyl patch and Kera-tek gel. The Utilization Review dated 10-1-15, non-certified the request for a hospital bed and in-home healthcare.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: hospital 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 (ODG), Knee Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter (Durable Medical Equipment).

**Decision rationale:** CA MTUS/ODG do not address requests for hospital beds. The patient has been approved for posterior lumbar fusion at L4-L5 and L5-S1 with a 2-day inpatient hospital stay. The request is for a post-op hospital bed; however, the medical records do not establish the necessity. There is no requirement to elevate the head of the bed greater than 30 degrees due to serious medical conditions such as congestive heart failure or pulmonary disease. The records do not indicate that the patient requires re-positioning of the body in ways not feasible in an ordinary bed. In addition, guidelines establish that most post-op patients such as this should not require bed rest as part of their treatment as it has potential debilitating effects. Therefore, the request for a hospital bed is not medically necessary or appropriate.

**In home healthcare:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** CA MTUS supports home health services if certain requirements are met. These services are normally reserved for patients that are homebound. When authorized, guidelines allow for no more than 35 hours/week of in home services. In this case, there is no information provided that justifies home health services. The patient is not homebound and is able to leave the home for appointments and other personal errands. In addition, when queried, the patient's physician indicates that he made the request for home health services solely based on the patient's request. Therefore, the request is not medically necessary or appropriate.