

Case Number:	CM15-0205046		
Date Assigned:	10/21/2015	Date of Injury:	12/26/2004
Decision Date:	12/03/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/19/2015

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: Emergency 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 54 year old male who sustained an industrial injury on 12-26-04. A review of the medical records indicates that the worker is undergoing treatment for right knee pain, degenerative joint disease, cartilage defect, trochlear groove, left knee status post total knee replacement, left knee contracture, low back pain- compensatory secondary to altered gait, and radicular symptoms left lower extremity. Subjective complaints (9-16-15) include an acute exacerbation of right knee pain, pain in the left knee and left hip, lower back pain flare secondary to altered gait (using cane for ambulation), and difficulty getting out of bed from a flat position. Objective findings (9-16-15) include an antalgic gait, tenderness to palpation in the paralumbar musculature, coccyx and sacral region, tenderness in the parathoracic musculature and muscle spasming, lumbar spine forward flexion of 30 degrees with pain, extension 10 degrees with pain, positive straight leg raise, (left) quadriceps atrophy, right knee crepitus, medial joint line tenderness and patellofemoral facet tenderness. Previous treatment includes medications and epidural injection. The requested treatment of 1 motorized bed was denied on 10-5-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized bed quantity requested: 1: 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-TWC) ODG, Low Back Chapter, 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) Low Back - Lumbar & Thoracic, Acute & Chronic, Mattress Selection.

Decision rationale: The requested Motorized bed quantity requested: 1, is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Low Back - Lumbar & Thoracic, Acute & Chronic, Mattress Selection note "Not recommended to use firmness as sole criteria" and "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain." The injured worker has right knee pain, pain in the left knee and left hip, lower back pain flare secondary to altered gait (using cane for ambulation), and difficulty getting out of bed from a flat position. Objective findings (9-16-15) include an antalgic gait, tenderness to palpation in the paralumbar musculature, coccyx and sacral region, tenderness in the parathoracic musculature and muscle spasming, lumbar spine forward flexion of 30 degrees with pain, extension 10 degrees with pain, positive straight leg raise, (left) quadriceps atrophy, right knee crepitus, medial joint line tenderness and patellofemoral facet tenderness. Based on these negative guideline recommendations and a lack of documented, detailed medical indication for this DME and the lack of provided nationally-recognized, evidence-based, peer-reviewed medical literature in support of this DME as an outlier to referenced guidelines, the medical necessity for this request has not been established. The criteria noted above not having been met, Motorized bed quantity requested: 1 is not medically necessary.