

<b>Case Number:</b>	CM15-0088322		
<b>Date Assigned:</b>	05/12/2015	<b>Date of Injury:</b>	08/29/2014
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: Florida

Certification(s)/Specialty: Neurology, Pain Management

### 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 52-year-old male who sustained an industrial injury on 08/29/14. Initial complaints and diagnoses are not available. Treatments to date include medications, back surgery, and medications. Diagnostic studies include a CT scan and lumbar x-rays. Current complaints include headaches and back spasms. Current diagnoses include status post lumbar fusion with degenerative disc disease. In a progress note dated 03/25/15 the treating provider reports the plan of care as CT scan, laboratory studies, and an electric lift type chair for home use. The requested treatment is an electric chair lift.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: Electrical Lift Chair (in months), QTY: 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation government clearinghouse guidelines - patient lift device.

**Decision rationale:** Guidelines support a patient lift device when: 1. The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease. 2. The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition. 3. The patient must be completely incapable of standing up from a regular armchair or any chair in their home. 4. Needs to have a two person assist to get out of chair and once standing, the patient must have the ability to ambulate. The medical records do not support that the insured has severe arthritis or the insured is incapable of standing up from a regular chair. As such, the medical records do not support the need for the device congruent with guidelines. The request is not medically necessary.