

<b>Case Number:</b>	CM15-0017254		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	06/18/1999
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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:

This 62 year old female sustained a work related injury on 06/18/1999. According to a progress report dated 10/14/2014, the injured worker complained of increased low back and bilateral wrist pain since her last examination. She complained of constant severe low back and bilateral lower extremity radicular pain. Pain was rated 9 on a scale of 1-10. She complained of severe bilateral wrist pain with numbness in the hands. Pain was rated 9. The injured worker ambulated with an antalgic gait and she used a cane. Diagnoses included lumbar radiculopathy and bilateral carpal tunnel syndrome. Treatment plan included oral medications, Toradol injection, vitamin B12 injections, a qualitative drug screen, home health care 8 hours Monday - Friday, easy rest adjustable bed and a large wheel chair to aid in ambulation. On 01/13/2015, Utilization Review non-certified easy rest adjustable bed quantity 1 and large wheelchair quantity 1. Guidelines referenced for the easy rest adjustable bed included Official Disability Guidelines Low Back, Lumbar & Thoracic (Acute & Chronic) page 63. Guidelines cited for the wheelchair included Medicare (<http://www.medicare.gov/Pubs/pdf/11046.pdf>). The decision was appealed for and Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Easy rest adjustable bed QTY1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- TWC, Low Back - Lumbar & Thoracic

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG® Treatment in Workers Compensation, 8th edition 2010 Low Back (updated 10/12/09) Procedure summary, Page 63, Mattress selection

**Decision rationale:** The requested Easy rest adjustable bed QTY1, is not medically necessary. CA MTUS is silent and ODG Treatment in Workers Compensation, 8th edition 2010 Low Back (updated 10/12/09) Procedure summary, Page 63, Mattress selection, noted "Not recommended to use firmness as sole criteria." The injured worker has constant severe low back and bilateral lower extremity radicular pain. Pain was rated 9 on a scale of 1-10. She complained of severe bilateral wrist pain with numbness in the hands. Pain was rated 9. The injured worker ambulated with an antalgic gait and she used a cane. 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, Easy rest adjustable bed QTY1 is not medically necessary.

**Large wheelchair QTY 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Criteria

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare (<http://www.medicare.gov/Pubs/pdf/11046.pdf>).

**Decision rationale:** The requested Large wheelchair QTY 1, is not medically necessary. Medicare (<http://www.medicare.gov/Pubs/pdf/11046.pdf>) note that a wheelchair is recommended for non-ambulatory patients. The injured worker has constant severe low back and bilateral lower extremity radicular pain. Pain was rated 9 on a scale of 1-10. She complained of severe bilateral wrist pain with numbness in the hands. Pain was rated 9. The injured worker ambulated with an antalgic gait and she used a cane. The treating physician has not documented that the injured worker is non-ambulatory. The criteria noted above not having been met, Large wheelchair QTY 1 is not medically necessary.