

Case Number:	CM15-0172706		
Date Assigned:	09/14/2015	Date of Injury:	11/29/1982
Decision Date:	10/14/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/01/2015

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: 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 62 year old female, who sustained an industrial injury on 11-29-1982. Diagnoses include morbid obesity, lumbar spondylosis without myelopathy, lumbar-lumbosacral disc degeneration, pain low back and meralgia parasthetica. Treatment to date has included surgical intervention (lumbar laminectomy L5-S1, 1991, and anterior cervical discectomy and fusion, 1999), postoperative physical therapy, diagnostics, medications, traction, TENS and chiropractic. Per the Initial Orthopedic Examination dated 6-04-2015, the injured worker reported chronic pain in the lower back with some numbness involving the right and left feet. Objective findings included flexion of 70 degrees, and extension of 10 degrees. It is noted that there is more pain with extension than with flexion. There is 15 degrees of lateral bending on the right and left and 20 degrees rotation on the right and left. There is positive lumbar tenderness and paraspinous muscle spasm. Per the medical records dated 11-04-2014, she reported low back pain with radiation into the hips. She rated the pain as 3-10 out of 10. Physical exam showed "excellent" range of motion. She was "able to bend forward to touch toes, smooth recovery, extension unimpaired." There was a negative straight leg raise test. The plan of care included weight loss strategies. The plan of care on 6-04-2015 included Flexeril, an adjustable bed and a scooter. On 8-07-2015, Utilization Review non-certified the request for an orthopedic adjustable bed and scooter citing lack of documented medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic Adjustable Bed QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The requested DME does not serve a purpose that cannot be accomplished without it. The prescribed equipment does not meet the standards of DME per the ODG. Therefore, the request is not medically necessary.

Scooter QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: The California MTUS section on powered mobility devices states: Power mobility devices (PMDs); Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The patient does not meet criteria as cited above and therefore the request is not medically necessary.