

<b>Case Number:</b>	CM15-0026549		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	12/31/2004
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 69-year-old male, who sustained a work related injury on 12/31/04. The diagnoses have included lumbar stenosis, right hip pain, right-sided plantar fasciitis chronic pain and depression. Treatments to date have included CT scan lumbar spine, Lidoderm patches, oral medications and epidural injections. In the PR-2 dated 1/2/15, the injured worker complains of persistent back and leg pain. He states pain is made worse with prolonged standing and walking and repetitive activities. He has tenderness over lumbar musculature and is positive for muscle spasms. He has some limited range of motion in his lower back. He has been approved for lumbar spine surgery. On 1/22/15, Utilization Review non-certified a request for a hospital bed for 4 weeks post-operative. Non-MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hospital Bed for 4 Weeks Post-operative:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Guidelines; Criteria for Hospital Bed.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Durable medical equipment (DME).  
<http://www.worklossdatainstitute.verioiponly.com/odgtwc/knee.htm#Durablemedicalequipment>.

**Decision rationale:** According to ODG guidelines, Durable medical equipment (DME) recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Many assistive devices, such as electric garage door openers, microwave ovens, and golf carts, were designed for the fully mobile, independent adult, and Medicare does not cover most of these items. See also specific recommendations here: Aquatic therapy; Bathtub seats; BioniCare #130; knee device; Bone growth stimulators; Braces; Canes; Cold/heat packs; Compression cryotherapy; Continuous flow cryotherapy; Continuous passive motion (CPM); Crutches; Cryocuff; Cryotherapy; Dynamic splinting systems; Dynasplint; Electrical stimulators (E-stim); Electromyographic biofeedback treatment; ERMI knee Flexionater #130;/ Extensionater #130;; Flexionators (extensionators); Exercise equipment; Game Ready? accelerated recovery system; Home exercise kits; Joint active systems (JAS) splints; Knee brace; Lymphedema pumps; Mechanical stretching devices (for contracture & joint stiffness); Motorized scooters; Neuromuscular electrical stimulation (NMES devices); Orthoses; Post-op ambulatory infusion pumps (local anesthetic); Power mobility devices (PMDs); RS-4i sequential stimulator; Scooters; Shower grab bars; TENS (transcutaneous electrical nerve stimulation); Therapeutic knee splint; Treadmill exerciser; Unloader braces for the knee; Vacuum-assisted closure wound-healing; Vasopneumatic devices (wound healing); Walkers; Walking aids (canes, crutches, braces, orthoses, & walkers); Wheelchair; Whirlpool bath equipment. The term DME is defined as equipment which:(1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005). In this case, the patient was approved to undergo bilateral L4-L5 decompression on December 5, 2014. However, there is no clear indication from the medical records reviewed that the patient will be homebound post surgery or that he will require positioning of the body, elevation of head, and special attachment to support the request. Therefore, the request for Hospital Bed for 4 Weeks Post-operative is not medically necessary.