

<b>Case Number:</b>	CM14-0001675		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	04/16/2007
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 51 year old female who reported an injury to her low back. The functional restoration program note dated 12/05/13 indicates the patient complaining of low back pain. There is an indication the patient has completed a physical therapy program but continues with range of motion deficits in both lower extremities. The patient also demonstrated 8 degrees of lumbar flexion, 14 degrees of extension, 17 degrees of left lateral flexion, and 14 degrees of right lateral flexion. The note indicates the patient showing no issues with her sleep. The clinical note dated 01/10/14 indicates the patient continuing with complaints of low back and leg pain. The note indicates the patient having previously undergone physical and aquatic therapy. Upon exam, the patient presented ambulating with a normal gait. Tenderness was identified throughout the cervical paraspinal musculature. The patient underwent a urine drug screen on 05/03/13. The results indicated the patient being compliant with her prescribed medications. The MRI of the lumbar spine dated 03/18/13 revealed mild foraminal narrowing bilaterally at L4-5. Mild central canal stenosis was also identified at L3-4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ORTHOPEDIC MATTRESS:** 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), Low Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section Knee and Leg Chapter, Durable Medical Equipment.

**Decision rationale:** The documentation indicates the patient complaining of neck and low back pain. The use of an orthopedic mattress would be indicated provided the patient meets specific criteria to include the equipment can withstand repeated use and can be used by successive patients and is generally useful to a person with an illness or injury. Orthopedic mattresses are not generally utilized by successive patients. Additionally, it is unclear if the patient has significant functional deficits that will benefit from the use of an orthopedic mattress. Therefore, this request is not medically necessary.

**H-WAVE PRESCRIPTION FOR HOME TREATMENT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT Page(s): 117-118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

**Decision rationale:** The use of an H-wave stimulation device is recommended for a 1 month home based trial provided the patient meets specific criteria to include the patient identified as having chronic soft tissue inflammation or findings consistent with diabetic neuropathy and the patient is utilizing the stimulation device as an adjunct to a program for functional restoration. No information was submitted regarding the patient's significant findings indicating neuropathic related pain. Additionally, no information was submitted regarding the patient's chronic soft tissue inflammation. Furthermore, no information was submitted regarding the patient's ongoing formal therapy. Given these findings, this request is not medically necessary.