

<b>Case Number:</b>	CM14-0018701		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	11/05/2008
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 has a subspecialty in Interventional Spine and is licensed to practice in California. 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 52 years old female with an injury date on 11/05/2008. Based on the 01/15/2014 progress report provided by [REDACTED], the diagnosis is: 1. S/P L/S Laminectomy, Discectomy (unknown date) According to this report, the patient complains of severe sharp pain in the lower mid back, with stiffness radiating to bilateral lower extremities with numbness, tingling, swelling, and weakness. The lumbar ranges of motion are decreased and painful. Tenderness to palpation of the lumbar paravertebral muscles was noted. The patient was ambulates with cane. There were no other significant findings noted on this report. [REDACTED] is requesting 1. Lumex rolled foam mattress 2. Acupuncture 2 times a week for 6 weeks 3. Pain management consultation within MPN 4. Continue care giver, 4 days a week for 8 hours/day for 12 weeks. There were no other significant findings noted on this report. The utilization review denied the request on 01/29/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 11/11/2013 to 04/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMEX ROLLED FOAM 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.

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

**Decision rationale:** According to the 01/15/2014 report by [REDACTED] this patient presents with severe sharp pain in the lower mid back that radiate to the legs. The provider is requesting Lumex Rolled foam mattress. The MTUS and ACOEM Guidelines do not address orthopedic mattress; however, ODG Guidelines provide some discussion and states, there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Under Durable Medical Equipment, ODG also states that DME is defined as equipment which is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury. In this case, an orthopedic mattress is not primarily used for medical purpose. Recommendation is not medically necessary.

**ACUPUNCTURE, 2 TIMES A WEEK FOR 6 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES; ACUPUNCTURE GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the 01/15/2014 report by [REDACTED] this patient presents with severe sharp pain in the lower mid back that radiate to the legs. The provider is requesting 12 sessions of Acupuncture. The UR denial letter states, this patient has completed 145 sessions since 06/2011 and there is not documentation of benefit, functional improvement, or decreased analgesic requirement resulting. For Acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain suffering and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement 1 to 2 times per year with optimal duration of 1 to 2 months. The UR alludes that the patient has had 145 sessions. Time-frame is not known. MTUS page 8 requires that the provider, provide monitoring of the patient's progress and make appropriate recommendations. In this case, the provider does not discuss the patient's treatment history nor the reasons for requested additional therapy. The requested 12 visits exceed what is recommended by MTUS Guidelines; therefore the request is not medically necessary.

**PAIN MANAGEMENT CONSULTATION WITHIN MPN:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7, page 127.

**Decision rationale:** According to the 01/15/2014 report by [REDACTED] this patient presents with severe sharp pain in the lower mid back that radiate to the legs. The treater is requesting for pain management consultation within MPN. The UR denial letter states "there is no documentation for rationale identifying the medical necessity of the requested referral." Regarding consultations, ACOEM states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the patient continues to experience chronic pain with some bladder issues that the treater has asked for pain management evaluation. The request appears reasonable and medically indicated. Recommendation is for authorization.

**CONTINUE CARE GIVER, 4 DAYS A WEEK FOR 8 HOURS/DAY FOR 12 WEEKS:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** According to the 01/15/2014 report by [REDACTED] this patient presents with severe sharp pain in the lower mid back that radiate to the legs. The treater is requesting continued care giver, 4 days a week for 8 hours/day for 12 weeks. Regarding home health-care, MTUS guidelines recommend medical treatment for patients who are home bound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. MTUS guidelines typically do not consider homemaking services such as shopping, cleaning, laundry, and personal care, medical treatments if these are the only services needed. In this case, the treater indicates that the patient needs help with transportation to and from Dr. appointment and therapy. However, there is no documentation of why the patient is unable to perform self-care. There were no rationales as to why the patient would need 8 hours a day, 4 day a week for transportation. No neurologic and physical deficits are documented on examination. Without adequate diagnostic support for the needed self care such as loss of function of a limb or mobility, the requested home health care would not be indicated. Recommendation is for denial.