

Case Number:	CM14-0151047		
Date Assigned:	09/19/2014	Date of Injury:	02/01/1996
Decision Date:	10/20/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/16/2014

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 Family Medicine 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:

This is a 65-year-old male patient who reported an industrial injury on 2/1/1996, over 18 years ago, attributed to the performance of his usual and customary job tasks. The patient is being treated for right knee advanced osteoarthritis, bilateral knee chondrocalcinosis, cervical degenerative disc disease, cervicgia, lumbar scoliosis, and lumbago. The patient is been demonstrated to have functional improvement with the provided medications and physical therapy. The objective findings on examination included diminished range of motion of the cervical spine and normal gait. The patient was recommended Therabands for exercise and was also recommended a therapeutic bed that bends.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therabands and therapeutic: Upheld

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) revised 2007 Chapter 12 pages 141-42; Chapter 12 pages 76-77; Official Disability Guidelines (ODG) Low Back chapter-Mattress selection; Exercises

Decision rationale: The use of a home exercise kits are not demonstrated to be medically necessary as there are many available alternatives for the neck exercises required to rehabilitate the neck, back, and knee. The request for authorization of the prepackaged exercise kits, pulleys, or Therabands for the rehabilitation of the neck, back, and knees is not demonstrated to be medically necessary and is not supported with objective medically based evidence. There was no objective evidence provided to support the medical necessity of the requested Therabands for use in a self-directed home exercise program. The provision of an exercise kit is not medically necessary, as the exercises appropriate for a self-directed home exercise program are not dependent upon a specific exercise kit or specifically Therabands. The requested Therabands are not medically necessary in order to perform the exercises required for the rehabilitation of the shoulder/neck. The exercises can be performed in a multitude of manners and a self-directed exercise program for conditioning and strengthening without the necessity of professional supervision. The request for the Therabands is not supported with objective evidence and is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The ability to perform therapeutic exercises for the neck, back, and knee is not dependent the use of Therabands. The patient should be in a self-directed home exercise program for conditioning and strengthening of the shoulder and neck to maintain function and range of motion. The request for authorization of the purchase of a therapeutic Mattress to replace his present mattress or bed is not supported with any objective evidence to support the medical necessity and is inconsistent with the recommendations of evidence-based guidelines. The patient is noted be able to ambulate and drive a vehicle. The patient is 18 years status post date of injury. The only rationale to support medical necessity of a new mattress is the continuation of low back pain. There is no rationale by the treating physician to support the medical necessity of the requested therapeutic Mattress over the present mattress or any other mattress. The use of a special mattress in not demonstrated to be medically necessary to treat the effects of the industrial injury. The objective findings documented and diagnoses do not support the medical necessity of a special mattress or bed. There is no demonstrated medical necessity for a therapeutic mattress for the diagnoses reported by the treating physician. The patient does not and did not meet the criteria of evidence-based guidelines for the provision of a special mattress. The prior mattress is not stated to be in disrepair. There is no objective evidence provided that the present mattress is not functional. The currently accepted evidence-based guidelines recommend an average medium firm mattress as there is no type of mattress that is medical